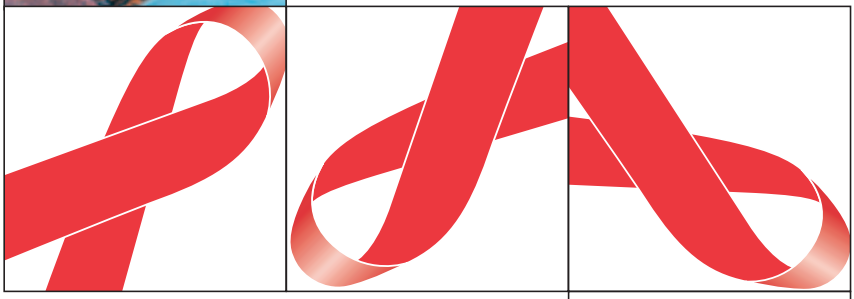
HIV Voluntary Counselling and Testing:

a gateway to prevention and care

Five case studies related to prevention of mother-to-child transmission of HIV, tuberculosis, young people, and reaching general population groups



Joint United Nations Programme on HIV/AIDS

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UNAIDS Case Study

June 2002

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NDP: Mentorship in the maternity ward in the Lubuto clinic

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UNAIDS BEST PRACTICE COLLECTION

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Abbreviations and acronyms

ANC	Antenatal care services
ARV	Antiretroviral
CTX	Co-trimoxazole prophylaxis
DART	Demonstration of antiretroviral therapy
DOTS	Directly observed treatment short-course
HAART	Highly active antiretroviral treatment
IEC	Information, education and communication
IPT	Isoniazid preventive therapy
KCTT	Kara Counselling and Training Trust
MCH	Maternal and child health
MSM	Men who have sex with men
NDP	Ndola Demonstration Project
NGO	Nongovernmental organization
OI	Opportunistic infection
PETRA	Perinatal transmission study
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PTC	Post-Test Club
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization
YFHS	Youth-friendly health services
ZAMBART	Zambia AIDS-Related Tuberculosis
ZAPSO	Zimbabwe AIDS Prevention and Support Organisation

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Foreword

By the end of 2001, the number of people estimated to be living with HIV/AIDS was 40 million, 28.1 million of whom (largely adults) are living in sub-Saharan Africa. In 2001, some 14 000 new infections were estimated to occur daily, and the majority of these were in developing countries among 15–49-year-olds, with nearly 50% occurring among 15–24-year-olds.

The *Declaration of Commitment*, which resulted from the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, highlighted the pressing need for countries to either develop or scale up voluntary HIV counselling and testing services. It noted the participating nations' commitment to: "by 2005, ensure that a wide range of prevention programmes [...] is available in all countries [...], including expanded access to voluntary and confidential counselling and testing".

Voluntary HIV counselling and testing is the process by which an individual undergoes counselling to enable him/her to make an informed choice about being tested for the human immunodeficiency virus (HIV). This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.

VCT is not only a key component of both HIV prevention and care programmes but is the *gateway* to both prevention and care. In order to respond effectively to options for each, it is preferable for one to know one's serostatus. The development of increasing numbers of effective and accessible medical and supportive interventions for people living with HIV/AIDS (PLWHA) means that VCT services are being more widely promoted and developed and many developing countries are gradually instituting VCT as part of their primary health-care package. VCT has also been shown to be a cost-effective HIV-prevention intervention.

Models of VCT service delivery in some of the key thematic areas, such as mother-to-child transmission (MTCT), tuberculosis (TB) and youth-friendly services, have been sprouting up in the Southern African region over the last few years. Although these have been few and far between, important lessons and approaches have been learnt and this booklet documents the experiences of three countries: South Africa, Zambia and Zimbabwe.

These models may seem specific to the countries in which they were developed but we believe that the approaches used can help other low-resourced countries to scale up much-needed VCT services.

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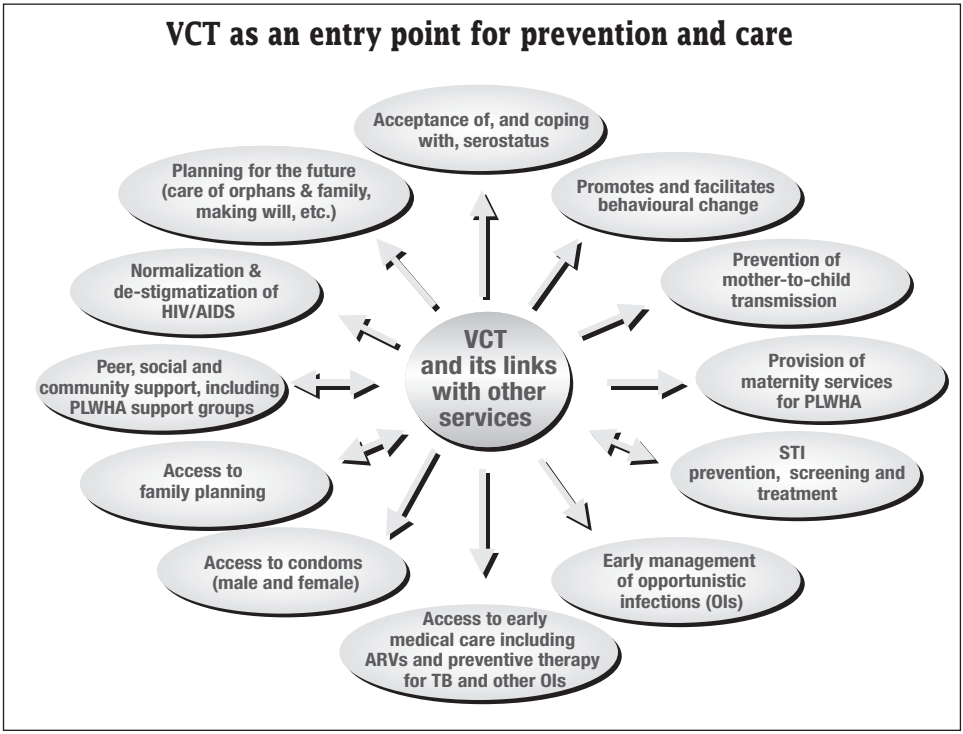
Introduction

Voluntary counselling and testing (VCT) is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV[1]. In recent years, voluntary HIV testing, in combination with pre- and post-test counselling, has become increasingly important in national and international prevention and care efforts. Knowledge of serostatus through VCT can be a motivating force for HIV-positive and -negative people alike to adopt safer sexual behaviour, which enables seropositive people to prevent their sexual partners from getting infected and those who test seronegative to remain negative. This intervention also facilitates access to prevention services for seronegative people and is a key entry point to care and support services for those who are HIV-infected. This includes access to interventions to reduce mother-to-child transmission (MTCT) of HIV, interventions to prevent opportunistic infections (e.g. tuberculosis preventive therapy and prophylaxis for other infections) and other medical and supportive services that can help HIV-positive people to live longer and healthier lives.

1 *VCT: UNAIDS Technical Update, May 2000*



Source: VCT: UNAIDS Technical Update, May 2000

Knowing and accepting one's HIV status enables more informed planning for the future, including for one's dependents. Programme experiences have also shown that VCT is one of the factors that help to reduce stigma and secrecy surrounding HIV/AIDS.

In order to facilitate a more rapid scaling-up of successful HIV/AIDS care and prevention activities, UNAIDS documents and disseminates models of 'best practice'. The need for documentation of VCT best practice models is greater than ever, given country pressures for identifying ethical approaches to counselling and testing, and for scaling up new or existing VCT services.

The aim of this booklet is to describe the experiences of, and challenges faced by, five programmes in sub-Saharan Africa, which developed effective practices and implemented novel

and successful approaches to VCT in relation to four key thematic areas:

- **prevention of mother-to-child transmission** (PMTCT)
- **tuberculosis** (TB)
- **young people**
- **general population groups.**

Many of the featured lessons and approaches in VCT may be transferable beyond country and culture, and strengthened through community mobilization and public policy measures.

This publication is divided into three chapters. This introductory chapter is followed by a chapter on VCT case studies in four key thematic areas. Each case study describes the background and history of the selected projects and organizations, provides an overview of the specific thematic area, and highlights key approaches to VCT service delivery in relation to the thematic area. The third chapter, on general VCT approaches and issues, both summarizes issues covered in the previous chapter and gives more in-depth information about the selected programmes in 14 areas, such as testing strategies, target population and service usage, community outreach, VCT service provision, training of VCT staff, post-test services, and others. Lessons learned and ongoing challenges are highlighted in each of these areas. At the end of the publication, conclusions are drawn from the five case studies.

1. Selection of case studies

In many countries, national and local initiatives promote VCT as a part of efforts to encourage more people to determine their HIV status. The number of VCT service providers, including government institutions, NGOs, and private institutions, increased over the last few years. Governments and international donors are strengthening their technical and financial support to improve quality and coverage of VCT services.

The core criteria of best practice that guide UNAIDS' efforts to identify, develop, and be a source of, international best practices (i.e. relevance, efficiency, effectiveness, sustainability and ethical soundness) have been applied by UNAIDS in the selection of the cases for this publication.

Five VCT programmes have been selected as they demonstrate successful approaches to promoting and delivering VCT services, providing care and support after testing, and preventing further transmission of HIV. All five programmes are in Southern Africa, namely South Africa, Zambia and Zimbabwe. They operate in low-resource settings and the experiences drawn can be helpful to nations and donors in moving beyond awareness of the magnitude of the problem towards greater action, particularly in scaling up VCT services.

Three case studies describe relatively new projects, initiated in 2000 in various primary health clinics and a hospital. VCT services were introduced or significantly expanded through the projects. These include:

- The **Demonstration of Antiretroviral Therapy (DART) Project** in Soweto, South Africa**,** implemented by the Perinatal HIV Research Unit of the University of Witwatersrand.

- The **Ndola Demonstration Project (NDP)** in the Copperbelt Province, Zambia, implemented by the Ndola District Health Management Team (DHMT), and supported by the USAID-funded LINKAGES Project.

- The **TB/HIV pilot project** in the Western Cape Province, South Africa, implemented by the Local Authority and the Provincial Administration of the Western Cape under the guidance of the Department of Health and WHO.

Two of the selected organizations are local NGOs in Zambia and Zimbabwe, which have been providing VCT services for several years:

- The **Kara Counselling and Training Trust (KCTT),** in Lusaka and Choma, in Zambia;

- The **Zimbabwe AIDS Prevention and Support Organization (ZAPSO)**, in Harare, Chitungwiza, Masvingo and Gutu, in Zimbabwe.

There are general principles for the delivery of VCT services that are applicable to any context anywhere in the world. These include the following:

- The services provided must be confidential; this means that the HIV test result is only revealed to the person tested and that everything that is discussed between counsellor and client during pre- and post-test as well as ongoing counselling is in confidence except when clients wish to include partners, relatives, friends, or others in the process (shared confidentiality).
- Attendance is voluntary; this means that the decision to have a HIV test must be entirely the choice of the individual.
- All clients accessing these services should be offered both pre-test and post-test counselling.
- Clients who test HIV-positive should not be discriminated against; and
- Clients should have access to ongoing prevention, care and support services.

Although all programmes reviewed embrace these same principles, they take a variety of approaches to VCT service delivery, depending on their particular focus on specific client groups, and/or emphasis on VCT as

entry points to specific interventions. These approaches are further elaborated below within the four key thematic areas.

Project location and country information

Ndola Demonstrations Project (PMTCT), Kara Counselling and Training Trust

Zambia

Surface area (square km)	753 000
Total population	10 million
GDP per capita (PPP US$)	756
Adult literacy rate (>15 years)	77.2 %
Life expectancy at birth	41 years
People living with HIV/AIDS	870 000
Adult HIV/AIDS prevalence (15-49 years)	19.95 %
Tuberculosis cases (per 100,000 people, year 1998)	482

ZAPSO

Zimbabwe

Surface area (square km)	391 000
Total population	12 million
GDP per capita (PPP US$)	2 876
Adult literacy rate (>15 years)	88 %
Life expectancy at birth	43 years
People living with HIV/AIDS	1.5 million
Adult HIV/AIDS prevalence (15-49 years)	25.06 %
Tuberculosis cases (per 100,000 people, year 1998)	416

The DART Project (PMTCT), The TB/HIV pilot project

South Africa

Surface area (square km)	1.22 million
Total population	42 million
GDP per capita (PPP US$)	8 908
Adult literacy rate (>15 years)	84.9 %
Life expectancy at birth	54 years
People living with HIV/AIDS	4.2 million
Adult HIV/AIDS prevalence (15-49 years)	19.94 %
Tuberculosis cases (per 100,000 people, year 1998)	326

Estimated figures from 1999 *Sources: Human Development Report 2001, UNDP. Report on the global HIV/AIDS epidemic 2000, UNAIDS. World Development Report 2000/2001, World Bank.*

2. VCT case studies in key thematic areas

2.1 VCT as an entry point to interventions that prevent mother-to-child transmission (MTCT) of HIV

> *"…By 2005, reduce the proportion of infants infected with HIV by 20% and, by 50% by 2010, by ensuring that 80% of pregnant women accessing antenatal care have information, counselling and other HIV-prevention services available to them, increasing the availability of, and providing, access for HIV-infected women, including voluntary counselling and testing, access to treatment, especially antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care."*
>
> **UNGASS HIV/AIDS Declaration of Commitment, June 2001**

Much has been learnt in recent years about the prevention of mother-to-child transmission (PMTCT) through antiretroviral (ARV) drugs and other interventions, in addition to primary prevention of HIV infection among women of childbearing age. These interventions rely substantially on identifying pregnant women who are infected with HIV. VCT is therefore an essential component of PMTCT programmes.

Two case studies related to VCT and PMTCT programmes are described in this section:

- The **Demonstration of Antiretroviral Therapy Project** (DART) in South Africa; and
- The **Ndola Demonstration Project** (NDP) in Zambia.

Overview of the Demonstration of Antiretroviral Therapy (DART) Project

The DART project is implemented by the Perinatal HIV Research Unit at the Chris Hani Baragwanath Hospital. Project sites are currently the hospital and two community health centres: Zola and Lillian Ngoyi, in Soweto, South Africa. The estimated population of Soweto, the largest township in South Africa and among the largest urban settlements in Africa, is between 2.5 and 5 million. The Chris Hani Baragwanath Hospital is one of the largest hospitals in the world and the only one serving the Soweto area. The Baragwanath Maternity Hospital is a referral centre for problem pregnancies from the midwifery delivery units of 11 community health centres in Soweto, including Zola and Lillian Ngoyi. The seroprevalence rate among pregnant women in the Chris Hani Baragwanath Maternity service was over 27% in late 2000. Young women seem to be at highest risk.

The hospital has offered voluntary HIV testing to pregnant women since 1987. In 1991, a Perinatal HIV Clinic, which provides care and counselling services to HIV-positive pregnant women, was formed in the Chris Hani Baragwanath Hospital. The Research Unit, which is linked to the Perinatal HIV Clinic, was and is involved in several PMTCT research projects and was also one of the multi-centre sites for the UNAIDS-supported PETRA study. The research findings of these studies, including the South African Interpartum Nevirapine Trial (SAINT), led, in September 2000, to the launch of the 'Demonstration of Antiretroviral Therapy (DART)' project. There are plans to scale up VCT service provision and access to PMTCT interventions to eight other clinics with midwifery obstetric units in the Soweto area.

The objectives of the PMTCT component of the DART project are to:

- provide improved access to VCT services and establish the feasibility and acceptability of rapid on-site testing;
- implement the HIVNET012 regimen for prevention of MTCT (a single oral dose of Nevirapine, self-administered by the mother at the onset of labour and a single dose administered to the baby within 72 hours of delivery);
- modify midwifery practices to minimize the risk of MTCT, e.g. avoidance of rupture of membranes,

episiotomies, and of oral suction of the newborn infant; and
- ensure safer infant feeding practices for HIV-positive women.

Overview of the Ndola Demonstration Project (NDP)

The NDP is implemented by the Ndola District Health Management Team and receives technical and financial support from the USAID-funded LINKAGES Project. The project is located in Ndola, the biggest town in the Copperbelt province in Zambia. Approximately 200 000 people live in the project demonstration area. The HIV prevalence rate is estimated to be 19.7% in the 15–19-year-old age group. Results from a 1997 assessment on infant feeding in the context of HIV/AIDS showed that, while more than 95% of Zambian infants are breastfed during their first year of life, only 26% aged 0–3 months are exclusively breastfed. There is insecurity among health workers in high HIV prevalence areas about the advice they should give to women about infant feeding. Most women do not know their HIV status. Stigma around HIV is still high in Zambia and women who do not breastfeed are believed to be HIV-positive.

Following recommendations based on this assessment, the 'Ndola Demonstration project to integrate infant feeding and HIV/AIDS counselling into maternal child health (MCH) and community services' was initiated in the first quarter of 2000. The objective of the project is to enable women and their families to make, and act effectively upon, an informed choice to optimally feed their infants in the context of HIV/AIDS, with social support from their partners and the community. A special effort is made to reach men and family members through the involvement of communities.

The Lubuto clinic and its six neighbouring health centres and surrounding communities in the Ndola District were selected as project sites because of the district's strong community mobilization efforts against HIV/AIDS. Starting in 2001, the project will be replicated in five other locations. The NDP is part of national efforts to address MTCT.

The key objectives of the project are to:
- integrate VCT and improved counselling on infant-feeding practices and maternal nutrition in health and community services;
- introduce VCT into MCH as an ongoing service available to pregnant women and their partners at antenatal care (ANC), postnatal and family planning services, curative services and through referral from community members;
- create an enhanced environment for counselling to ensure privacy and confidentiality;

- strengthen the referral systems between clinic, community and district hospitals; and
- address the issue of stigma connected with not breastfeeding in the project design and implementation.

Box 1

VCT and PMTCT interventions

At the end of 2000, it was estimated that 3.8 million children had died of AIDS before their 15th birthday, since the start of the epidemic. Another 1.3 million children are currently living with HIV, and most will die before they reach their teens. Over nine-tenths of these children were born in sub-Saharan Africa. The vast majority of children with HIV are infected in-utero, at the time of labour and delivery, or after birth through breastfeeding. In the absence of interventions, around a third of HIV-positive mothers will pass the virus to their infants through one of these three routes.

Most MTCT of HIV occurs at the time of delivery or late in pregnancy. Between one-third and half of infections occur during breastfeeding. Several factors, not all of which have been fully elucidated, influence the likelihood of a baby getting infected, including viral, maternal, obstetrical, fetal and neonatal factors. High maternal viral load (i.e. the levels of virus in a pregnant woman's body fluids), such as at the time of seroconversion or in advanced disease, is considered to be a major factor in transmission.

Interventions to prevent MTCT of HIV include therapeutic and obstetric interventions and modification of infant-feeding practices. Women's knowledge of their serostatus is essential if they and their families are to benefit from PMTCT interventions. Some measures, such as infant-feeding counselling and avoidance of invasive procedures during delivery, should be standard with all pregnant women in high-HIV-prevalence areas, independent of knowledge of HIV status.

In high-income countries, most HIV-infected pregnant women choose to take combinations of ARV drugs, which dramatically reduce the risk of MTCT of HIV.

—>

These regimens are relatively expensive and complicated to administer. Access to these drugs is therefore minimal for the majority of women in developing countries. However, more recent trials (notably the HIVNET 012) have shown encouraging results with less expensive, shorter regimens. Following these results, increasing numbers of developing countries have set up pilot projects, which give HIV-positive pregnant women access to ARV interventions to prevent MTCT of HIV during labour and delivery. Access to VCT is therefore a prerequisite.

The risk of transmission through breast milk depends on factors such as the health and immunological status of the mother, breast abscesses, mastitis, nipple cracks, oral thrush in the child, and patterns and length of breastfeeding. Transmission rates seem to be higher with mixed, rather than exclusive, breastfeeding. Infant-feeding counselling can help women to make an informed choice to optimally feed their infants.

PMTCT strategies include:
- primary prevention of HIV among future parents;
- improved access to family planning services and information for HIV-positive parents; and
- prevention of HIV from mother to child when the mother is HIV-positive.

Key approaches taken by the NDP and DART project in relation to VCT and PMTCT include:
- promotion of VCT services among pregnant women attending ANC services and their partners;
- integration of VCT services in MCH services;
- combination of VCT and infant-feeding counselling;
- involvement of VCT counsellors in ARV interventions;
- training of antenatal clinic staff and midwives;
- access to psychosocial support and medical care; and
- involvement of community service providers in supporting mothers and promoting VCT.

Promotion of VCT services among pregnant women attending ANC services and their partners

Women attending antenatal services in hospitals and clinics very often have little or no knowledge about MTCT and VCT. This is the case even in high-HIV-preva-

lence settings. Health workers and VCT counsellors in the two projects therefore conduct group information/ education and demonstration sessions for all attending women in the ANC waiting rooms. In the NDP, health talks at the clinics and other venues in the community (e.g. growth monitoring points) are also given by community service providers (see Box 2) and the project is very successful in involving men as facilitators. During these sessions, a variety of issues concerning pregnancy and delivery are discussed, including HIV/AIDS, prevention of MTCT, and the benefits of VCT. Prevention of MTCT is addressed in broad terms during health talks. More in-depth discussions take place during individual counselling sessions once a woman has decided to undergo a HIV test.

Women are advised to discuss VCT with their partners and encourage them to come for a HIV test. Members of community service groups (see Box 2) also target men during their information and education activities to improve men's understanding of maternal and child health issues (including PMTCT), raise their interest in VCT, and make them more supportive towards their partners.

Integration of VCT services in MCH services

The set-up and operations of antenatal care services vary from clinic to clinic within the NDP and DART projects. Identification of appropriate entry points for integration of VCT services takes into consideration the need to minimize waiting times and emotional stress for clients.

In the **DART** project, all women undergo individual pre-test counselling at their first antenatal visit. At the end of the counselling session, the VCT counsellor asks the client to sign a form in the patient folder, indicating if she wants to:

- test and receive the results the same day;
- test and receive the result later;
- test another time;
- not have a test.

DART: A VCT counsellor invites women for pre-test counselling at the ANC unit at the Lillian Ngoyi clinic

Uptake of the HIV test in the DART project is very high. Over 90% of women attending antenatal services in the Chris Hani Baragwanath Hospital, and approximately 88% in the Zola Clinic, decided to have a HIV test.

Those who want to know the result the same day receive post-test counselling at the end of the ANC visit.

Among women who decide not to test during their first visit, awareness of and knowledge about VCT is increased through pre-test counselling. Women are also encouraged to bring their partners for VCT.

In the **NDP**, pregnant women are invited during antenatal visits and other occasions to utilize VCT services at any time during pregnancy or afterwards. This invitation also includes their partners. Pre-test counselling is only made available to those who decide to test. In some project clinics, women are asked during ANC health talks to raise their hands if they are interested in VCT. Those indicating interest are gathered in a group where HIV/AIDS, MTCT and VCT issues are discussed in more detail before they see the VCT counsellor. Nurses feel that it reduces stigma and normalizes VCT use if women are encouraged to openly show their interest in HIV testing. Besides that, women's increased level of knowledge facilitates pre-test counselling. Test results and post-test counselling are available the same day or several days later, depending on when the specimen was sent to the laboratory. VCT service use is also encouraged at postnatal, family planning and curative services.

In both projects, it is emphasized during pre-test counselling that testing is voluntary and confidential and that a woman can still choose not to be tested even if she had indicated earlier that she was interested. Some women, for example, first want to consult their partner. Counsellors make it clear that VCT services are available at any time later during pregnancy, as well as after delivery—for example, during family planning or treatment clinic sessions, as well as during sessions at baby clinics. Project managers recognize that it is particularly important in a hospital and clinical setting that women do not feel coerced into testing because they fear exclusion from antenatal services if they do not agree to be tested.

In both projects, a relatively small number of women do not return for their test results (e.g. in the DART project, 9.7% of all women tested and 12.4% of women who tested positive at the Zola Clinic never pick up their test results). According to counsellors in the two projects, there is sometimes an opportunity to talk to women and encourage collection of HIV test results when they come for ANC follow-up visits. In the DART project, ANC nurses also encourage women to follow up, as they can see in the patient folder if the HIV test result has not been collected. However, counsellors describe a fine line between encouragement, on the one hand, and putting pressure on women, on the

other: *"It is important that nurses and counsellors accept a woman's choice not to collect her results even if it is sometimes hard because it means that she will not benefit from a PMTCT intervention".*

Post-test counselling is always offered, with the main goal being to help the women understand their test results and initiate adaptation to their seropositive or seronegative status. If the HIV test result is negative, counsellors explain during post-test counselling the particularly high risk of MTCT if women get infected with HIV during pregnancy or after delivery if they are breastfeeding. They encourage women to protect themselves from infection through condom use or abstinence during pregnancy. Condoms are available free in the waiting rooms.

Combination of VCT and infant-feeding counselling

For pregnant women whose HIV test is positive, post-test counselling focuses on: reducing the risk of MTCT with an emphasis on different infant-feeding options and on ARVs, if available; safer sex, including strengthening the necessary negotiation skills; and identifying ways to inform the partner and family members. This requires that counsellors have adequate knowledge of the personal situation of a HIV-positive woman, including such factors as the socioeconomic situation in the community and the availability and costs of replacement feeding.

Counsellors in the **NDP** put particular emphasis on finding out as much as possible about the specific life circumstances of a woman in order to carefully weigh the advantages and disadvantages of different feeding options and help her make an appropriate decision. Ongoing counselling and post-test support groups can support women in their decision. Counsellors emphasized that helping a woman who tested positive to make an informed choice about how to feed her baby is more than just telling her about potential risks and different feeding options.

> "*Counselling women to make an informed choice requires deep understanding of the social issues, compassion, knowledge of the household situation, the ability to communicate complex concepts, and the ability to emotionally support women in a decision that affects themselves, their children and their entire family."*
>
> **Ellen Piwoz, Member of the Ndola Formative Research Team, in: *HIV/AIDS and Infant Feeding: Risks and Realities in Africa*, AED, June 2000).**

Before the launch of the NDP, infant-feeding recommendations for women of known and unknown HIV status were developed to guide health workers,

including VCT counsellors. The recommendations were based on formative research to ensure their feasibility, appropriateness and relevance for the communities taking part in the NDP. Research results helped health workers to develop a better understanding of breastfeeding practices in the communities, availability and costs of replacement food, household economics, and people's knowledge in relation to HIV/AIDS and MTCT. It was found that breast-milk substitute with the cheapest available formula or cow's milk was not affordable for most households in the Ndola District. As an alternative, exclusive breastfeeding during the first six months is promoted in the NDP.

Involvement of VCT counsellors in ARV interventions

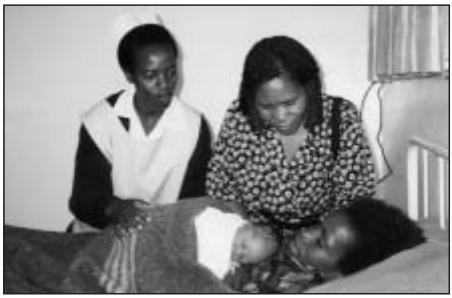
In the **DART** project, VCT counsellors distribute the ARV drugs during post-test counselling to woman who tested positive and agreed to the intervention. This ensures that women are in possession of the drug at the onset of labour. This modifies the initial practice within the programme of waiting to distribute the ARV drug to women at their ANC visit during the 35th week. Delaying the distribution resulted in many women never receiving the tablet because they did not return, or because they delivered earlier than expected. Counsellors have the difficult task of counselling women who are under extreme emotional pressure and, at the same time, explaining the details of MTCT, the ARV intervention, and infant-feeding options. Counsellors felt that it is important for women to come back for ongoing counselling and/or attend the support group to reinforce guidance provided during post-test counselling. Project managers reported positive experiences using this approach. Of the 57 HIV-positive women who had delivered during the first five months of the project and received the ARV drug at the Zola Clinic, 88% reported having successfully self-administered the drug.

Not all women who tested positive agreed to the ARV therapy. A counsellor explained why: *"From our experience, the reasons are that some clients are in denial about the result, or they do not believe in the medicine, or they are in shock"*. Of the HIV-positive women who got their results at the Zola Clinic in a five-month period, 87.9% were dispensed with a Nevirapine tablet. The other 12.1% did not take the drug, despite reminder letters, inviting them to come to the clinic.

Training of antenatal clinic staff and midwives

In both projects, health workers dealing with antenatal women receive HIV/AIDS and PMTCT training in order to respond better to the needs of the growing numbers of women who

know their HIV status. In the NDP, midwives also receive mentorship.



NDP: Mentorship in the maternity ward in the Lubuto clinic

Midwives are trained through the projects to avoid invasive procedures during deliveries so as to reduce the risk of HIV transmission. These include routine rupturing of membranes, routine episiotomies, and suctioning of the newborn baby. Elective ('non-emergency') caesarean sections are rarely an option in this part of the world. Nurses in the post-natal ward support women who choose to formula-feed by showing them the correct methods of preparing the formula[2] and feeding the baby. VCT managers in the DART project explained that the frequent rotation of health workers in the hospital and clinics makes it difficult to ensure that every nurse in the labour ward has received PMTCT training.

There are different approaches in the clinics reviewed regarding 'shared confidentiality' with midwives and nurses in the post-natal ward. In the DART project, counsellors indicate on women's ANC card if they received Nevirapine (which is an indication of their HIV status). This is to ensure that nurses in the labour ward administer the Nevirapine syrup to the baby within 72 hours of delivery.

In the NDP, it is up to the individual woman to disclose her status. A coded letter combination is written on the ANC card of every pregnant woman who goes for VCT without revealing the test result. All women who are administered for delivery are asked by the midwives how they intend to feed their babies, to avoid initiation of breastfeeding in cases where a mother plans not to breastfeed.

Access to psychosocial support and medical care

Both projects organize support groups and offer ongoing counselling to give emotional support to women after VCT and counsellors also encourage women to attend after delivery. These services offer opportunities to discuss in more depth issues around ARV interventions, infant feeding, and protection during pregnancy. Group support and counselling can help seropositive women to cope with their status.

[2] *With coupons handed out in the DART project, infant formula can be obtained for a reduced price (10 Rand instead of 26 Rand for a 500g tin). US$1 = 8 Rand (approximately in May 2001).*

Discussions and role-plays can help women to disclose their status to their partners and family members.

The hospital support group in the **DART** project meets on clinic days in the waiting room of the Perinatal HIV Clinic, so that all women attending antenatal services can participate. As one counsellor reported: *"Some women come to the group every week even if they have no appointment. They enjoy being around, talking to newcomers and also having fun. Some also continue coming after they have given birth and tell the group about their experiences. It's easier to discuss, ask questions and learn from others. I had one patient I didn't believe would come to terms with her status but today she is the one in the group who talks a lot and tells how she feels. Women become more comfortable in the group".*

DART: A mother introduces her baby to the support group for HIV-positive women at the Perinatal HIV Clinic at the Chris Hani Baragwanath hospital

HIV-positive women in the two projects do not have access to HAART, except for the short-course ARV intervention in the DART project to prevent MTCT. A pregnant woman in the DART project said, *"I am very glad that my baby will be saved from this disease but what worries me is that it might grow up without me because there are no drugs for mums. I found out that I am positive but there doesn't seem to be much help for me. What can be done for me?"*

All pregnant women who tested positive at the Chris Hani Baragwanath Hospital[3] are referred to the Perinatal HIV Clinic within the hospital, where they are attended by doctors. The general health status of women is checked at every visit in view of their HIV infection and their required antenatal care. Referrals within the hospital are arranged, if necessary. After delivery, mothers and babies are referred back to their nearest primary health clinic. Pregnant women, who utilized VCT services in the antenatal clinics of Zola and Lillian Ngoyi community health centres, continue to use the same antenatal services where they are attended by nurses, who usually don't know the women's HIV status. Infants born to HIV-positive mothers in the DART project are followed up by project doctors at routine immunization appointments at the Well Baby Clinic at 6, 10 and

3 *The Baragwanath Maternity Hospital is a referral centre for problem pregnancies from the midwifery delivery units of 11 community health centres in Soweto.*

14 weeks, and 9 and 15 months. Infants are tested for HIV at one year of age. During these routine visits, a weight check is performed, feeding practices assessed, and babies are examined and referred where indicated. From six weeks till one year of age, all babies receive co-trimoxazole as well as vitamins.

Project managers in the **NDP** reported that the quality of MCH services has improved since the project started, including antenatal, labour and delivery, postnatal, family planning and child health services. According to them, all women receive better care and support before and after delivery. However, the availability of essential drugs required for basic care, such as malaria prophylaxis or de-worming drugs, cannot always be ensured due to financial constraints.

Box 2

Involving community service providers in supporting mothers and promoting VCT

In the communities surrounding the NDP clinics, a number of community support groups have developed over the years, including neighbourhood health committees, home-based care groups, mother/father support systems, positive living groups, traditional birth attendants, child health promoters, growth-monitoring promoters, and community-based distributors. These groups collaborate with the clinics on different assignments and extend health care and support to the community level. All of them together have approximately 610 members who work on a voluntary basis. Through the NDP, community health promoters and health workers receive the same training on issues related to HIV/AIDS, PMTCT and VCT to ensure that coherent messages go out to pregnant women and their partners. By February 2001, approximately 160 members (60% of them men) had been trained.

VCT counsellors play an important role in helping HIV-positive women to come to a decision about how to feed their infants but, after delivery, women need further support in their choice, whether they breastfeed or give replacement feeding. Many projects end at the clinic level and don't go further to provide care and support at community level. In the NDP, the community service providers became partners in PMTCT interventions and provide ongoing support to mothers when they return home after delivery. They ensure that women

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and their babies are referred to the clinics more reliably and earlier in case there are health problems, especially related to infant feeding.

A member of the **mother/father support system** explains: *"We come to the clinics every morning to find out who delivered. We visit all mothers in the first days after delivery. We don't know about the HIV status of the women who delivered. Because we visit all women after delivery there is no room for speculation in the community about the reason for the visit."*
During the home visits, the reasons for a woman's infant feeding choice are not questioned. Support group members are trained to recognize breast problems such as mastitis, cracked nipples, or breast abscess, and refer women and their babies to the clinic, if necessary. If a woman gives replacement feed, community volunteers show her how infant formula is prepared, what tools are best used to measure the right amount of water and formula, and how to feed the baby. Follow-up house visits are made regularly and progress reported to the clinic counsellors.

NDP: Men who are members of a mother/father support group in Ndola

Men's involvement in community groups, such as the mother/father support system, helped to improve their understanding of maternal and child health (MCH) issues, including PMTCT, and raised their interest in VCT. Project managers hope that positive male role models will increase other men's interest in VCT and that education through community service providers will make more men supportive of their partners.

Several community group members have been trained as **community counsellors** to provide emotional support, particularly to pregnant women and mothers with babies, as well as their families**.** On request, community counsellors do house visits and some also welcome clients in their own homes to ensure confidentiality. Community counsellors are not informed about the HIV status of clients but clients often disclose their status to them. Community counsellors participate in a similar course as VCT counsellors (see section 3.8 'Training of VCT personnel').

Growth-monitoring points are established in public places and the weighing is carried out by **growth-monitoring promoters** who are trained to look at the general health of babies and refer those who are underweight to the hospital. Growth-monitoring promoters also promote VCT and give health talks at the weighing points about MTCT and infant-feeding options.

Summary

The NDP and the DART project demonstrate that the introduction of VCT and PMTCT interventions in antenatal settings needs to be accompanied by measures that facilitate and support women's decisions regarding VCT and PMTCT interventions. This includes providing a supportive environment. Pregnant women have to be made familiar with the issues involved to help them understand the implications of a HIV test and PMTCT interventions. In the NDP, community health promoters collaborate with clinics in educational activities and promoting VCT. In the DART project, the fact that all antenatal women receive pre-test counselling is, according to project managers, closely related to high uptake of testing.

Experiences from the two projects also show that supporting women who test HIV-positive to make an informed choice about infant feeding and decide about ARV interventions requires more than informing them about the advantages and potential risks. Close involvement with clients during post-test counselling, empathy, knowledge of women's life circumstances, and the ability to explain complex concepts are very important. Ensuring good quality of pre- and post-test counselling, including infant-feeding counselling, through ongoing training and mentorship (see sections 3.8 and 3.9) is therefore high on the agenda of both projects. Ongoing counselling and post-test support groups play a vital role in supporting women in their decision. In the NDP, broad community involvement, particularly of men, in prevention education and care activities reportedly helped reduce stigma and encouraged more men to come forward for HIV testing and to support their partners.

The two case studies also show that training of health workers dealing with antenatal women, including training in basic counselling skills, increases their knowledge and capacity to better respond to the care and support needs of the growing numbers of women who know their HIV status.

2.2 VCT as a link between HIV/AIDS and TB programmes

> *"We have seen a sea change in the way many governments approach the HIV/AIDS epidemic. The possibility of treatment has given new hope, making countries scale up their efforts to fight the disease, through prevention and better diagnostics, as well as beginning to provide care for those already infected."*
>
> **Dr Gro Harlem Brundtland, Director-General, WHO, press release 25 June 2001**

Tuberculosis (TB) is the most common opportunistic infection and the leading cause of death among HIV-infected persons. TB patients' knowledge of their HIV status through VCT allows for access to a wider spectrum of care and support. Despite the close link between HIV/AIDS and TB, the HIV/AIDS/STI and TB programmes in many countries are not working together but function in parallel with separate responses.

This case study describes specific approaches of the **TB/HIV Pilot Project** in the Central District, Western Cape Province, South Africa, to link the two programmes.

Overview of the TB/HIV Pilot Project

South Africa is facing one of the worst dual epidemics of tuberculosis and HIV. A review of the South African National TB and HIV/AIDS/STI programmes recommended improved collaboration between the two programmes. This led to the establishment of four pilot projects in different provinces in South Africa to assess the operational issues of implementing a comprehensive package of care and support for people living with HIV/AIDS, including patients co-infected with TB and HIV, using VCT as an entry point.

The HIV prevalence rate among antenatal women in the Western Cape Province was 8.7% in 2000. The TB incidence in the Central District in 1999 was more than 500 cases per 100 000 people. The TB/HIV Pilot Project became operational in the first quarter of 2000, initially in five primary health clinics. Seven more clinics were included in the project over the course of a year. The project serves a population of approximately 296 000 and is implemented by the Local Authority and the Provincial Administration of the Western Cape in conjunction with the Department of Health. The project is informed by the ProTEST Initiative (see Box 4) and supported by WHO and UNAIDS. Three urban sites were reviewed for this publication: Langa and Chapel Street com-

munity health clinics, and Green Point community health service.

The key objectives of the project are:

- to increase access to voluntary counselling and HIV testing, decrease the barriers to VCT, and improve the quality of VCT;
- to improve comprehensive HIV/AIDS/STI/TB care and referral and to ensure continuity of care;
- to provide isoniazid preventive therapy (IPT) and co-trimoxazole prophylactic therapy to HIV-positive clients and to evaluate its utility, feasibility and cost implications; and
- to facilitate collaboration between TB and HIV/AIDS/STI programmes at district and community level and between private and public stakeholders.

Box 3

HIV/AIDS and tuberculosis

The burden of tuberculosis is closely linked to the HIV epidemic. Tuberculosis is the most common opportunistic infection and the leading cause of death among HIV-infected persons. About a third of the 34.3 million PLWHA worldwide are co-infected with *Mycobacterium tuberculosis.* HIV prevalence is the single most important factor in determining TB incidence and TB outcomes.

HIV, by attacking the immune system, increases the risk of developing active TB for those who have been infected with TB earlier in life (latent TB) from 10% per lifetime to 10% per year. When HIV-positive people become newly infected with *Mycobacterium tuberculosis,* they are more likely to progress to active tuberculosis. TB has an adverse effect on HIV by accelerating the natural progression of HIV infection. As a result of HIV infection, many TB patients are infected and die from other opportunistic infections. HIV-positive TB patients have mortality rates that are two-to-four times higher than those of HIV-negative patients.

Increasing TB cases in PLWHA also pose an increased risk of TB transmission to the general community, whether or not HIV-infected.

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For example, in South Africa, the number of TB cases reported was relatively stable between 1980 and 1989. Fuelled by the rise in HIV prevalence, reported TB cases have increased from about 60 000 in 1989 to 147 578 cases in 1999—an increase of 146%. It is estimated that 50% of TB patients in South Africa are HIV-positive. In 1999, 4.2 million South Africans were HIV-positive, compared to 3.6 million in 1998 and 2.7 million in 1997. Some 1.7 million HIV-positive South Africans will get TB before they die. Less than 10% of people in South Africa know their HIV status and many of those who do know their status do not reveal it.

Early case detection and treatment of TB can slow the progression of HIV infection and help to reduce transmission of TB. It is therefore essential that TB patients have access to effective diagnosis and treatment. TB can be treated and cured at relatively low cost if the completion of treatment is ensured through proper case management, which is crucial to preventing drug resistance. The most efficient approach to detecting more TB cases involves intensified case-finding in settings where PLWHA are concentrated, including VCT centres.

HIV-positive people with latent tuberculosis may benefit from preventive treatment, including isoniazid preventive therapy (IPT), which is aimed at decreasing the risk of a first-ever episode of TB and at decreasing the risk of recurrence in someone who has previously had tuberculosis.

Scenario before the introduction of the TB/HIV Pilot Project

A baseline assessment carried out before introducing the TB/HIV Pilot Project showed that the collaboration between the TB and the HIV/AIDS programme in the Central District was not optimal. The lack of integration had significant implications for the breadth and quality of care provided for HIV-infected people.

In general, testing for HIV was performed only on clinical grounds to confirm the diagnosis in those with clinical manifestations suggestive of HIV infection. TB patients were not automatically referred for a HIV test but usually only if they did not recover

despite treatment. They were, in most cases, referred at an advanced stage of the disease and often terminally ill. The fact that TB patients were rarely tested for HIV at an early stage of the disease was a barrier to access to more comprehensive care and support, including prophylactic treatment against other opportunistic infections.

HIV-positive clients were not treated holistically, they had no access to isoniazid (IPT) preventive therapy (TBPT), rarely received prophylactic treatment, and there was no standardized management of opportunistic infections. The majority of health workers did not have up-to-date training in integrated care and management for STIs, TB and HIV. Instead, they were specialized in only one area. As a consequence, the referral system was weak and clients who went to the TB clinic were only treated for TB, and STI patients treated only for STIs.

HIV clinics for patients whose status was known were established in many clinics and were open once a week. However, HIV-positive clients were usually only seen on this specific day, whereas TB and STI clinics were held on different days and attended by different doctors and often different nurses. This meant that patients who attended the HIV clinic had to come back on another day if they needed an X-ray or were on TB treatment, and were then often seen by different health workers.

As not all health workers were knowledgeable about HIV/AIDS, only a few were involved with HIV-positive clients or had access to their medical records. This increased stigmatization of patients within the clinic. One of the nurses states, "*Before the project, I wasn't much involved with the HIV clinic. For me, it has changed my thinking a lot in terms of HIV. I can deal much better with clients who are positive. Before the training, I had a very negative attitude about HIV. I think it comes from the way you were brought up; that forms your attitudes. For me, it has been a struggle to accept clients, especially when you know the sexual practices of some of them. Why should we be less judgemental just because we are nurses? We are all human.*"

Testing was not performed in the clinics and test results came back from the laboratory only a week or more after testing. A significant number of clients did not return for their test results and, as a consequence, also did not receive adequate care and support.

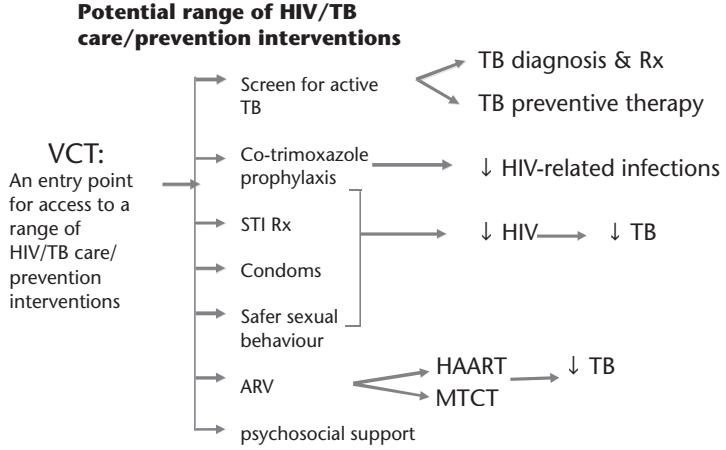
Box 4

ProTEST Initiative

The ProTEST initiative, coordinated by the World Health Organization (WHO), aims to promote HIV voluntary testing as a key to a more coherent response to tuberculosis in high-HIV-prevalence settings. The initiative embraces district-level field experience in several pilot sites, combining efforts in combating HIV and tuberculosis intended to reduce the HIV/tuberculosis disease burden. This will contribute to the development of a strategic approach that can be promoted as an expansion in scope of the internationally recommended tuberculosis control strategy. The name 'ProTEST' reflects the promotion of voluntary HIV testing, as an entry point for access to HIV and tuberculosis prevention and care.

The ProTEST initiative's objectives are to reduce the combined burden of tuberculosis and HIV through a concerted approach that will: reduce the number of people becoming infected with HIV; reduce the number of people transmitting both HIV and *Mycobacterium tuberculosis*; and reduce the risk of those infected with both HIV and *M. tuberculosis* developing active tuberculosis.

ProTEST: Operationalizing the link between TB/HIV activities



Source: TB/HIV Pilot Project

Since the initiation of the project, guided by the ProTest Initiative, remarkable progress has been made in improving linkages and collaboration between TB and HIV programmes and strengthening the referral system between the two programmes. Key approaches include:

- active promotion of VCT among TB and other clinic clients;
- introduction of rapid on-site testing;
- active TB case-finding among clients testing HIV-positive;
- improved access to a comprehensive package of care;
- continuity of care through improved training of health workers and community service providers; and
- involvement of stakeholders in project coordination.

Active promotion of VCT among TB and other clinic clients

TB/HIV project: A VCT counsellor gives a health talk promoting VCT at the Chapel Street Clinic

Through the distribution of information materials and general health talks by VCT counsellors in the waiting rooms, all clients attending the health centres, including TB patients, are encouraged to utilize VCT services.

During individual consultations, doctors and nurses advise *all* TB and STI patients, and those attending family planning services, to access voluntary counselling and testing services. According to project managers, numbers of VCT clients increased sharply with the active promotion of VCT services. Most importantly, doctors report that more people choose to be tested at an earlier stage of infection. However, VCT service utilization among TB patients is still relatively low. As one nurse explains: *"TB clients say they would worry more if they did a HIV test. They rather want to have the TB treated and maybe come back another time for VCT".*

Introduction of rapid, on-site testing

TB/HIV project: A nurse/VCT counsellor explains to a client his HIV test results

Rapid testing has been introduced and test results are available in less than an hour. As a consequence, more clients receive their test results. The project coordinator reports that the acceptability of HIV testing increased among clients since the HIV test results could be collected the same day.

Active TB case-finding among clients testing HIV-positive

The common approach to TB case-finding involves detecting cases among people presenting with symptoms to general health services. A more efficient approach is to find cases in settings where PLWHA are concentrated. Together with VCT services, active TB case-finding has therefore been introduced through the TB/HIV Pilot Project. All clients who test HIV-positive (and haven't already been referred from the TB clinic) are screened for tuberculosis, as they are more susceptible to TB infection. Thus cases of active and latent tuberculosis are identified and TB treatment or IPT can be initiated.

Improved access to a comprehensive package of care

All clients testing HIV-positive at the project clinics have access to a free comprehensive package of care, including isoniazid preventive therapy[4], treatment for active TB, and co-trimoxazole (CTX) prophylaxis. Whereas TB patients were, in most cases, only treated for TB before project introduction, the improved referral system between the TB and the HIV programmes (including the active promotion of VCT) has allowed for access to a broader spectrum of care for TB patients who test positive.

Health workers carry out a baseline examination with every client testing positive. Clients are staged according to WHO clinical staging and screened for tuberculosis (if they haven't already been referred from the TB clinic) and for co-trimoxazole prophylaxis. A clinical chart is used for this purpose, including a questionnaire for screening. If a patient is interested and eligible for IPT[5], an X-ray and a Mantoux test are carried out. Clients are started on a six-month isoniazid therapy when the

[4] *The benefit of IPT is for the individual rather than for reducing TB incidence in the population. It reduces the likelihood of the individual developing TB.*

[5] *Indicators are: client above 14 years, no TB symptoms, ability to come for monthly follow-up, appearing healthy.*

X-ray read by the doctor is normal and when the Mantoux test is positive. Patients who show symptoms of HIV-related disease are started on life-long CTX prophylaxis.

HIV-positive clients who are on prophylactic treatment are followed up on a monthly basis and seen by a doctor at least once every three months. Those who are not on prophylactic treatment are encouraged to see a doctor every three-to-six months if they are asymptomatic, and otherwise every month. Clients are also encouraged to come to the health centre as soon as they have any medical problems or show any symptoms of disease. HIV-positive women have an annual PAP (cervical) smear. Treatment for opportunistic infections is available and PLWHA also receive vitamins on a regular basis and nutritional supplements, if needed. All HIV-positive clients are re-screened for WHO staging on a three-monthly basis. Thus diagnostic and treatment delays are reduced.

In most clinics, following the introduction of the project, HIV-positive clients can attend the HIV, TB and STI services any day of the week. There are still specific days allocated for specialist clinics attended by doctors. HIV-positive clients are usually advised not to come on the day when the TB clinic takes place in order to reduce the risk of nosocomial TB transmission. "*We educate HIV-positive people not to wait until they are very sick but to come to the clinic immediately if something is wrong. They know they will always be treated at the clinic,"* explains one of the clinic managers.

Ongoing counselling is offered to all VCT clients and post-test support groups are established in most project clinics.

Continuity of care through improved training of health workers and community service providers

Managers report better continuity of care since the project started. Clients can now be sure to receive comprehensive and holistic treatment irrespective of their symptoms, as all nurses receive ongoing training in prevention and management of opportunistic infections and are knowledgeable about HIV/TB/STI care and treatment. The majority of health workers have also been trained as VCT counsellors. According to the project manager, the quality of care has improved as has nurses' understanding of the issues involved, making them feel more confident and comfortable in dealing with HIV-positive clients.

A nurse at the Langa clinic explains: "*You give the sad news that someone is positive. It is a big shock for this person. The morale*

is down, there is fear of stigma. The person is entangled in many things like how to break the news to the partner and family; maybe the person is unemployed. The person needs confidence that being HIV-positive is not the end of the world. So you have to take this person in totality. The approach for us is different now. If you have a patient in front of you, then you don't only perceive him as a TB client but you see the whole client with a variety of symptoms. Then you explain all the things you can do for the patient".

TB/HIV project: DOTS treatment supporters trained in HIV/AIDS issues and VCT promotion in the Langa clinic

Community members, who are involved as DOTS treatment supporters, received training on issues related to HIV/AIDS and now also promote VCT. One of them reports*: "We are very excited that we received training because now we have tools, whereas before we were doing work that had to do with HIV but we had no knowledge about it".* AIDS home-based care providers have also been trained on DOTS and complement the community treatment supporters.

Involvement of stakeholders in project coordination

It is a priority of the TB/HIV Pilot Project to involve community stakeholders in the planning, development and coordination of the project. This includes, for example, a broad stakeholder forum in Langa, representing traders, schools in the area, traditional healers, political parties, NGOs and CBOs. Where health committees exist, they were involved in the coordination of the project from the beginning. Some committees became strong partners in mobilizing community members to become actively involved in providing information about HIV/AIDS, TB and VCT and promoting awareness of services available at the health centres. As the clinic manager at Langa recalled: "*They (*health committee members*) had a full understanding that there is an epidemic of HIV. It was a blessing to them that the project was introduced and they grabbed the opportunity for Langa. It has made a dramatic change for them".*

Project management also set up a technical committee to oversee the project, which includes representatives of provincial and local authorities, local health committees, NGOs and each project clinic.

Summary

Since the initiation of the TB/HIV Pilot Project, clients in the project clinics profit from closer collaboration between the TB and HIV/AIDS programme. As TB is the most common opportunistic infection, all TB as well as STI patients and those attending family planning are encouraged to utilize VCT services. At the same time, all VCT clients who test positive are screened for TB. All HIV-positive clients have access to free comprehensive care, including TB treatment, TB preventive therapy, and co-trimoxazole prophylactic treatment. Project experiences show that training of all health workers in HIV/TB/STI care and treatment ensured continuity of care. Most nurses were also trained as VCT counsellors and learned how to carry out HIV tests, which facilitated integration of VCT services and generally improved the quality of care. The involvement of community stakeholders is seen as a priority in the TB/HIV Pilot Project and some community health committees became strong partners in education about, and mobilization for, VCT.

2.3 VCT and young people[6]

> *"…In addition we must also ensure young people's access to youth-friendly health services that provide HIV testing and counselling, treat sexually transmitted diseases, and offer frank and unabashed information and services on how sexually active young people can protect themselves and their partners from infection".*
>
> **– Carol Bellamy, Executive Director, UNICEF, speaking at the Organization of African Unity Summit on HIV/AIDS, TB and Other Infectious Diseases, Abuja, Nigeria, 26 April 2001.**

The majority of new HIV infections in developing countries occur among young people aged 15 to 24 through unprotected sexual intercourse, with girls being particularly vulnerable. There are increasing efforts to interest young people in utilizing VCT services. However, few programmes are currently providing counselling and testing as well as post-test services that are tailored to the special needs of young people.

This case study describes the approaches towards young people of the **Kara Counselling and Training Trust** (KCTT), an NGO with branches in Lusaka and Choma, Zambia.

6 *The definition of young people in this case study is those aged 14–24.*

Overview of the Kara Counselling and Training Trust[7]

The population of Zambia is approximately 10 million people and 58% of the population is below 19 years of age. At the end of 1999, Zambia had one of the highest HIV prevalence rates in sub-Saharan Africa, with nearly one-in-five persons between 15 and 49 years of age infected. However, there are encouraging figures in a June 1999 report of Zambia's Ministry of Health that shows a drop in HIV prevalence among child-bearing women aged 15 to 19 in four sites in Lusaka, from 28% in 1993 to 15% in 1998.

KCTT is a Zambian NGO, which started as a 'drop-in centre' that provided HIV information and counselling to the general public in 1989. It also provided the basis for the formation of the first support group for people living with HIV in Zambia, which has continued to have an important role in HIV advocacy and education, and in challenging stigma and denial in Zambia. In 1992, confidential VCT services were introduced at one of KCTT's facilities. For a number of years, KCTT was the only place where people in Lusaka could go for counselling and testing, outside medical settings. Rapid testing with same-day results was introduced in 1996. The majority of KCTT's VCT clients are young people between 18 and 29. KCTT has recently applied for funding for a project to scale up VCT services for young people, with a special focus on girls.

In Lusaka, KCTT maintains two free-standing sites and four sites that are attached to clinics. In addition, KCTT also has a branch in Choma, a town in the Southern Province of Zambia, with separate training facilities and a VCT centre. The catchment area of the Choma VCT facility also includes rural communities.

KCTT's mission statement is 'to promote integrated human development by providing counselling, training, care and other related services that respond to current psychosocial needs in Zambia. KCTT provides the following services to the general public:

– voluntary counselling and testing with same-day test results;

7 *At the time of the survey, some of the excellent services KCTT has been providing in the past were compromised due to financial constraints experienced in the last quarter of the year 2000. This, together with a temporary reduction in the number of counsellors due to the same financial problems, resulted in lower numbers of people using, and benefiting from, VCT services offered by KCTT. The case study looked at all programme components and services related to VCT provided by KCTT, including those that were, at the time of the survey, scaled down.*

- general counselling;
- training programmes in counselling skills and community home-based care and support;
- a vocational-skill-training programme and therapeutic support for people living with HIV/AIDS (duration four months);
- HIV/AIDS outreach education programmes involving people living with HIV/AIDS;
- a residential training programme for orphaned and vulnerable girls who are socioeconomically severely disadvantaged; and
- a hospice facility for chronically and terminally ill, socioeconomically disadvantaged people.

Box 5

VCT and young people

Many adolescents in sub-Saharan Africa are sexually experienced. In Zambia, for example, 31% of women aged 15–19 and 65% of young men are sexually experienced but not yet married[8]. Most adolescents, when entering into sexual relations for the first time, do not use any form of contraception. This leaves them vulnerable to HIV infection, STIs, and unplanned parenthood. Access by young people (particularly girls) to sexual and reproductive health services in developing countries remains a major challenge. Young people's knowledge about sexual and reproductive health and availability of respective services is generally not very high. Communication with parents about sexual issues is rare and most information comes from peers and is often incorrect. Lack of skills to negotiate safe sexual behaviour, poor access to contraceptives, and vulnerability to sexual abuse put young people at highest risk of HIV infection.

In many cultures, it is socially unacceptable for young people to be sexually active unless they are married. As a consequence, sexually active young people don't openly talk about their experiences with adults, including health workers. They fear that confidentiality might not be maintained in health facilities. In addition, young people tend to seek services only when symptomatic

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8 *Demographic and Health Surveys, 1994–1998*

(e.g. from STIs). Health workers' attitudes towards teenage sexuality are sometimes negative and young people perceive them as intimidating. These factors, among others, contribute to young people's reluctance to use VCT services.

Other barriers to service use by young people include misconceptions, fears and a low risk perception. Innovative approaches are required to help young people, particularly girls, to overcome these barriers and take advantage of counselling and testing services. Among the challenges facing programmes interested in providing VCT services to young people are:

- youth-oriented advertisement and promotion of services;
- youth-friendly counselling and referral to other health and psychosocial support services;
- non-judgemental health-care providers; and
- access to particularly vulnerable young people, such as out-of-school and street children.

Clear national policies are needed to address the minimum age of VCT service use without parental consent. Currently, in Zambia, young people must be 18 years of age to access VCT services without parental consent. However, they are reportedly less likely to utilize VCT services if they need their parents' consent to do so.

KCTT works towards increasing young people's utilization of VCT services, including post-test support services. To achieve this, the organization takes the following approaches:

- youth-oriented outreach activities to educate and mobilize young people for VCT;
- access to partner and pre-marital counselling and testing for young couples;
- youth-friendly VCT service provision;
- provision of ongoing counselling and youth-friendly post-test clubs; and
- operational research about VCT and young people.

Youth-oriented outreach activities to educate and mobilize young people for VCT

KCTT managers reported that outreach activities play a crucial role in young people's decision to use VCT services. This is not only as a result of their being informed about the existence of VCT services and having the procedures explained, but also by involving them in discussions about the advantages and disadvantages of VCT. Through interaction with outreach workers, some of young peo-

ple's doubts and anxieties are addressed and they develop a better understanding of the value of knowing their HIV status. Data from the KCTT VCT centres and reports from counsellors confirmed that very few young people drop into the VCT centres without having been invited, and most visits are in response to invitations from outreach workers. KCTT has two approaches to community outreach: an outreach programme with HIV-positive young people, which is targeted more at groups, and a community mobilization programme that is targeted at individuals. Outreach workers are trained through KCTT and receive support through mentorship.

The young HIV-positive outreach educators, who are mostly in their early twenties, generally address groups of people—for example, at schools, anti-AIDS clubs, clinics, churches and work places.

They talk about their personal experiences, give educational talks, promote VCT and stimulate discussions and role-playing about HIV/AIDS and related issues. Outreach educators also frequently visit drop-in centres for street children and talk to young people who are out of school and work on the streets. Educators receive 5000 Kwacha[9] for each outreach session.

KCTT: young KCTT outreach workers with their supervisor at Hope House

The other strong component of KCTT's VCT promotion efforts is the community mobilization[10] carried out by young community members. Young people were recruited to reach out to their communities and promote VCT services mainly through individual contacts. Most mobilizers are in their early twenties and have either completed high school or dropped out at a higher grade. A number of them have been recruited from post-test clubs.

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9 *1000 Kwacha is approximately US$0.25.*

10 *Ideally, KCTT community mobilizers work for each VCT centre but, due to downsizing, they operated only at one clinic at the time of the case study assessment. Numbers of clients dropped significantly in centres where mobilization stopped in 2000.*

KCTT: young KCTT community mobilizers at Chawama clinic

Mobilizers work in the community and approach people on the street, in market places, shops and bars and at the clinics to give them information about HIV and VCT. They also go from house to house and respond to invitations from schools, youth groups and churches. Their main target group are young people between 18 and 30 years of age, whom they involve in discussions about HIV/AIDS, STIs and VCT to motivate them to use the VCT services. They hand out invitation slips and receive 2000 Kwacha for each person who follows up on their invitation to the VCT centre. Mobilizers find it more difficult to approach girls than boys (and substantially lower numbers of girls use VCT services).

One of the KCTT mobilizers said: *"It is often difficult to make people come for VCT. Many of them come when we tell them that they get free treatment for STIs and TB after they are tested*[11]*. We really like our job but mobilizing people and going out into the community can also be a risky job because some people think that all mobilizers are HIV-positive and they are not treating us well. But others are very keen when we approach them and say 'take me there now'".*

Access to partner and pre-marital counselling and testing for young couples

Through active promotion of partner and pre-marital counselling and testing, KCTT attracts many young couples in their late teens and early twenties. Counsellors report that more and more young people decide to have a HIV test together with their partner at the onset of a new relationship or before getting married. KCTT has also built links with some churches, which encourage pre-marital counselling and testing.

According to a study carried out at KCTT (see under Operational research), the majority of interviewees under the age of 20 intend to get tested together

[11] *People who utilize KCTT's VCT services have some access to free medical care, including TB and STI treatment. See also Chapter 3 under 'Post-test services'.*

with a partner before engaging in sexual activity or getting married. An 18-year-old VCT client explained: "*With the girl I am with now, since I have agreed to be in a relationship with her it's better to go for a HIV test. She agreed to go for a test and she turned out to be negative. Myself, I am HIV-negative, so we just have to be very faithful now. If I ever have another girlfriend, I will have to ask again because I want to defend my life*".

Youth-friendly VCT service provision

Box 6

'Youth-friendly health services' (YFHS) in Zambia

'Youth-friendly health services' is a countrywide clinic-based peer education programme supported by, among others, CARE and UNICEF, with a strong focus on adolescent sexual and reproductive health. In many health centres in Zambia, peer educators are available for adolescent clients to listen to their problems, provide information and distribute condoms. Young people reported that it is easier for them to approach their peers with issues related to sexuality as confidentiality is important. Clinics usually provide separate space for YFHS to ensure privacy.

Peer educators from YFHS function as a link between young people and health workers and refer their clients to the clinic and VCT services, where necessary. They also conduct outreach education for schools and communities. YFHS are integrated in all the clinics where KCTT operates and VCT counsellors and community mobilizers collaborate with the peer educators from YFHS who are reliable partners in VCT mobilization. Counsellors also refer young clients to YFHS, particularly for discussions on safer sex and distribution of condoms.

After KCTT outreach workers visited schools, students often came in groups to the VCT centre because their interest had been piqued and they wanted to find out more about the services. Counsellors organize group education sessions and general counselling and offer VCT to those over 18. KCTT uses group education as a way to introduce the concept of VCT to young people

under 18, make them comfortable with the environment and reduce their fears of future visits. KCTT counsellors believe that once a young person has been to a VCT site, knows when and how it operates, and has a better understanding of HIV/AIDS and VCT, she/he will be more likely to utilize VCT services in the future.

Health workers, particularly in sexual and reproductive health services, sometimes have the attitude that young people should be abstinent and therefore don't always treat them in a friendly and respectful way. For this reason, KCTT's VCT counsellors receive basic child/youth-friendly training that enables them to be aware of, and adequately respond to, the special problems and needs of young people. The curriculum of a more in-depth two-week child/youth-friendly course has been tested recently, and all VCT counsellors will gradually undergo this training.

Since 1989, KCTT's training centre has also provided HIV/AIDS awareness and basic counselling training for nurses at health centres. Several hundred nurses have been trained to increase their understanding of young people's sexuality and to be non-judgemental in interactions with them.

KCTT's VCT services are free of charge. Opening hours of the centres are 8am–5pm during weekdays, which is convenient for young people who can choose to come for VCT before, during or after school. One free-standing site and one based at a health centre are also open on Saturday mornings.

Provision of ongoing counselling and youth-friendly post-test clubs

Young people who test positive need help in coping with their status, including disclosure to their families and sexual partner/s. Young people also report that practising safer sex after VCT is often difficult to maintain and HIV-positive and -negative young people alike require further encouragement and support.

Besides offering ongoing counselling, KCTT has set up post-test clubs (PTC) at all VCT sites to provide HIV-positive and -negative clients with a safe and confidential space where they can work through the consequences of HIV testing and try to come to terms with their serostatus in a group setting. The majority of club members are young people, although clients of all age groups are welcomed. The clubs meet every two weeks under the guidance of a KCTT counsellor, and community mobilizers as well as youth-friendly peer educators are involved in the facilitation. Young post-test club members in Choma, Southern Province, are also

encouraged by KCTT counsellors to participate in community projects. While post-test clubs are considered very valuable, programme managers report that other ongoing support services for HIV-positive young people are desperately needed. Consequently, the programme also seeks to build the capacity of youth organizations providing post-test support to HIV-negative and -positive young people and to strengthen the collaboration and referral system with VCT services.

The KCTT VCT manager reported: *"People get encouragement in the PTC. The clubs have contributed a great deal to reduce stigma against HIV-positive people as club members of all ages interact freely in the group, usually without knowing each others' status. Some said that before they tested and joined the club they were uncomfortable to be close to HIV-positive people but coming to the club changed that. Their misconceptions about HIV-positive people were corrected".*

Operational research about VCT and young people

KCTT is frequently involved in operational research projects intended to guide and improve its programming approaches. For example, in June 2000, a small-scale study with 30 young participants between 15 and 20 years of age was carried out in Lusaka, in collaboration with KCTT and with support from UNICEF Zambia, to identify factors that influence young Zambians' decisions regarding the use of VCT services. The most prominent motivating factors included:

- interaction with peer outreach educators, which gave young people a chance to discuss and reflect on VCT;
- the desire to know where one 'stands in life';
- plans to get married;
- the desire to change the lifestyle and reduce sexual activity or become abstinent (make a 'fresh start');
- encouragement from sexual partners to use VCT services;
- encouragement from friends who had used VCT services; and
- membership in community groups that supported VCT, particularly anti-AIDS clubs.

Factors that had a negative impact on the decision to attend VCT included:

- the perception that one would not be able to cope with a positive test result and would be too disturbed to continue school or would commit suicide;
- the belief that being HIV-positive is equivalent to having AIDS and being near death;

- the belief that one would die sooner if one's HIV-positive status were confirmed;
- the belief that one is not vulnerable to HIV infection despite risky sexual behaviour;
- the perception that peers are discouraging about attending VCT services; and
- fear of rejection by family and friends, and of discrimination and stigmatization.

Attending VCT services also requires that young people first acknowledge that they are sexually active, which was reportedly much more difficult for girls than for boys. According to the study, negative perceptions of sex appear to make it particularly difficult for girls to talk about sexual issues and decide to attend VCT services, especially when they have no symptoms of illness.

Summary

Response to the special needs of young people is high on KCTT's agenda and the organization takes a variety of approaches to encouraging young people to utilize VCT and post-test services. Experiences show that peer outreach activities are crucial to helping young people overcome barriers to service use. The provision of partner and pre-marital counselling and testing attracts many young people, and some churches became partners in the promotion of these services. Close collaboration between VCT services and the clinic-based peer education programme 'Youth-friendly health services' facilitates referral of young people. VCT counsellors receive child/youth-friendly training to deal with prejudices against young people's sexuality and be understanding of, and open to, their problems and needs. Very importantly, post-test emotional support is provided through ongoing counselling and youth-friendly post-test clubs. Broader support networks in the community are, however, urgently needed.

2.4 VCT services addressing general population groups

> *"When properly carried out, voluntary counselling and testing can help break the vicious circle of fear, stigma and denial."*
>
> ***Report on the global HIV/AIDS epidemic*, UNAIDS, June 2000**

In addition to services more directly focused on pregnant women, young people and TB clinic clientele, VCT service models include those that address the general population. In many sub-Saharan countries, VCT remains a relatively new programme intervention with the few services avail-

able being concentrated in urban areas. There is broad agreement on the urgent need to make services available to semi-urban and rural populations.

This case study draws on the experiences of the **Zimbabwe AIDS Prevention and Support Organisation** (ZAPSO), in Zimbabwe.

Overview of the Zimbabwe AIDS Prevention and Support Organisation

Zimbabwe is one of the countries in sub-Saharan Africa most severely affected by HIV. In Harare, the capital, with a population of a million, sentinel surveillance in antenatal clinics indicates that approximately 25% of women are infected with HIV. ZAPSO is a Zimbabwean NGO providing small-scale VCT services. Until September 1998, when ZAPSO set up the first voluntary HIV counselling and testing service, there was nowhere in Harare, outside medical settings, where people could obtain VCT.

HIV affects all areas of Zimbabwe. VCT services are largely concentrated in urban sites and ZAPSO aims to provide increased services for people in rural areas. Following the development of a first site, ZAPSO is adapting its VCT model for other sites. It illustrates how an NGO can develop its services to meet the needs of the communities it serves. It also reflects the difficulties that small local NGOs, which often rely on different sources of funding, have in expanding their services. Three models of VCT delivery are described:

- the first ZAPSO model is a free-standing VCT site in central Harare, which services a population working in the central city;
- the second model is a VCT service attached to a busy primary health-care clinic in a high-density Harare suburb;
- the third model that ZAPSO has used is free-standing sites in rural/semi-rural settings.

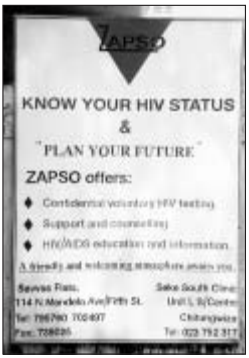
Free-standing VCT in an urban setting

A situational analysis showed that, although many people in Harare had good basic knowledge about HIV, they did not know about the benefits of HIV testing and very few people had been tested. In the survey of more than 2000 people living in Harare, 60% said that they would consider VCT if it were available. They indicated that the most important element of the service was that confidentiality could be assured.

In 1998, following this situational analysis, ZAPSO set up its first VCT site in the city centre of Harare with the aim of making the centre easily acces-

sible to working people. This is a free-standing VCT service and people can attend for anonymous VCT without an appointment. Many people who attend this centre are working nearby and more men than women are seen, reflecting the local working population. Although the counsellors welcome couples and acknowledge that VCT is most effective when couples can be seen together, most people attend as individuals and many are reluctant to return with their partners/spouses. People who attend value the anonymity and convenience of the site, particularly as they can use the services after work or during their lunch hours.

Provision of continuing support has, however, proved difficult and the formation of a post-test club was not successful. Programme managers suggest that this may have been because the centre does not serve a particular community and the site attracts people from a wide geographical area. Counsellors at the Harare site felt that ongoing counselling and support was important for some clients following VCT, especially for those who tested seropositive. When individuals needed further post-test counselling, this could be carried out by the counsellor, but long-term follow-up is seen to be beyond the remit of ZAPSO and referrals are made to general counselling services and PLWHA support groups, where necessary. An effort has been made to ensure that the centre is welcoming and comfortable.



Welcome to the ZAPSO VCT centre, Harare

VCT integrated into primary health-care services

ZAPSO established a second VCT site within a primary-health-care clinic in January 2000 in a high-density suburb, Chitungwiza, 30km outside Harare. A process of consultation with the local community and health-care staff working in the clinic was undertaken in order to provide a service that was acceptable to the local community. The health-care staff also received training so that they could appreciate the benefits and cautions associated with VCT and work together successfully with counselling staff. To date, women and people with HIV/AIDS-related symptoms are more likely to attend.

There are close links with other health-care staff in the centre, which facilitate

referrals between services, including family planning, STI screening and treatment, TB services and PMTCT interventions for pregnant women. Here, the counsellors work closely with clinic staff to provide VCT for both clinic attendees and people from the surrounding community. Cross-referral between the clinic and VCT has proved to be very helpful. Post-test support is a very strong feature of these services. Several post-test support groups have been set up, some providing income-generating activities including market gardening and the selling of secondhand clothes.

Free-standing VCT in rural and semi-rural settings

ZAPSO recently established two new free-standing sites 300km south of Harare at a rural growth point, which is the first rural-based VCT centre for the country. In recognition of the lack of VCT services available for the rural and peri-urban population of Zimbabwe, ZAPSO responded to the request of the Provincial Governor of Masvingo to come and set up two VCT centres in his Province—one in the town and one in a rural growth point, Gutu. Both centres in Masvingo and Gutu became operational in the second quarter of 2001 and have met with an overwhelmingly positive response.

In the initial planning phase for the project, ZAPSO carried out a situational analysis using Participatory Reflection and Action (PRA) methods to determine the communities' views, perceptions and attitudes to HIV/AIDS and VCT in Gutu District. The team recruited 12 local people to assist in the information-gathering using semi-structured interviews, and an additional two people to join the ZAPSO team in their focus group discussions.

The PRA exercise exposed a wealth of information on the community's perceptions and attitudes to HIV/AIDS and their views and feelings on the introduction of a VCT service in Gutu. From the high response rate seen in the semi-structured interviews and the attendance rate at the focus groups, it was noted that there was a great eagerness to participate in HIV prevention initiatives at community level and a growing willingness to know one's HIV status.

A Community Action Plan (CAP) was developed from the results of the PRA. This CAP was shared with all stakeholders and was helpful when mapping out the project activities and devising the monitoring and evaluation tools for the project. The focus group information also revealed the communities' preference for the VCT centres to be away from hospital settings. People commented on a lack of trust regarding health staff's ability to maintain confidentiality in these smaller communities.

ZAPSO recruited a project coordinator, two nurse counsellors and two community mobilizers to cover the two sites in early 2001. A multidisciplinary team was necessary to meet the community mobilization activities required to compliment the centre. The staff works closely with the District AIDS Committee to build community confidence in the service.

Using the lessons learnt from the opening of the first two centres in Harare and Chitungwiza, ZAPSO intensively advertised the opening of the centres in Masvingo and Gutu using the local press, passing out flyers and making announcements on the radio. To date, more women than men have attended. A high number of young men attended during the first three weeks of opening as it coincided with school holidays. Despite the lack of same-day testing at the centres, over 95% of clients tested for HIV antibodies have returned for their results, showing a commitment to knowing their status and confidence in the service provided.

Summary

The ZAPSO services indicate that different models may suit different communities. It highlights the importance of participatory community planning to determine the acceptability and model of VCT service proposed before VCT services are implemented. Local community factors, such as community perception of confidentiality within health-care facilities, were found to vary in different settings and this influenced the choice of VCT model. ZAPSO's experiences showed that it is essential in the implementation of any new service that community-based activities be carried out to build awareness of the service, that the service meet the community's expectations and needs, and that ongoing psychosocial support be offered to those diagnosed with HIV.

3. General VCT approaches and issues

3.1 Common goals and principles

Pre- and post-test counselling is part of the services provided at all VCT sites. Services are **voluntary**, and are used by clients who have already decided that they want to take a HIV test. In the DART project, *all* pregnant women undergo pre-test counselling and then decide if they want to test.

Confidentiality is an essential component of all services while, at the same time, openness towards partners and families about the HIV status is promoted. Services are **anonymous** and results are never given over the telephone or disclosed to another person. Clients are identified only by numbers even if they are registered under their names. VCT clients in the NDP receive, on request, the laboratory reports with the client's name and HIV test result.

Counselling sessions are **tailored to the individual or couple** attending. Although there are common elements in the content of the counselling sessions, the counsellors note that HIV testing is often only one of a number of the important issues that are covered in counselling sessions. Relationship difficulties and family problems are also often underlying factors in the wish to obtain VCT. **Continuity of counselling** is also emphasized, with the majority of clients seeing the same counsellor for pre- and post-test counselling.

3.2 Major cross-cutting challenges

> *"Stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must be addressed."*
>
> **United Nations General Assembly, Declaration of Commitment on HIV/AIDS, June 2001**

Throughout the programmes reviewed, the following two major cross-cutting challenges were reported by programme managers and counsellors alike:

- reducing stigma and discrimination; and
- disclosure of HIV status to partners and families.

Reducing stigma and discrimination

Although the number of people accessing VCT centres continues to grow, there is still a lot of fear and misperception associated with HIV, especially around knowing one's status. All programme managers reported that, despite the high prevalence of HIV in their country, HIV continues to be something that people are reluctant to be open about, constituting a major barrier to HIV prevention and care efforts. Fear of stigmatization still prevents many people from getting tested and determining their HIV status. Health workers from several projects confirmed that it also prevents people from accessing care and support services after counselling and testing. "*People don't want to go to the support group because they don't want other people to see them there,*" reports one of the nurses.

Some project managers, such as in the TB/HIV pilot project, reported that it has been difficult to recruit HIV-positive people to participate in programme planning and implementation and outreach activities. Although some would like to get more involved, many are reluctant to be open about their seropositive status because they fear stigma and discrimination. Major efforts are needed to reduce stigma and discrimination in the communities.

When properly carried out, VCT can help break the vicious circle of fear, stigma and denial. KCTT managers reported that, in communities where services have been provided for several years, VCT has been 'normalized' and increasing numbers of people use the services. NDP managers report that the broad involvement of women and men in educating and sensitizing their community has slowly reduced stigma and discrimination, and more and

more women and men share their test results with partners and families.

Disclosure of HIV status to partners and families

Counsellors in all projects report that one of the most significant challenges in their work is to help HIV-positive clients overcome their reluctance to tell their sexual partners their HIV status. Disclosure and discussion of VCT remains particularly difficult for women. *"Women are soft negotiators. Even if they are negative and they know that they are at risk, they have fear. A few have the strength to discuss the test and initiate condom use at home. There is a lot to be done, especially for poor women or women in rural areas who depend solely on the husband's income,"* observes a counsellor at ZAPSO. The ZAPSO counsellors have developed a series of techniques to help facilitate disclosure, which include role-plays. They also offer to provide a neutral space away from the home and facilitation to help clients disclose their test results to partners or significant others.

Counsellors in the NDP and the DART project also report that women have particular difficulties disclosing their HIV-positive status to their partners and families because they fear rejection, abuse and discrimination. In some cases, these fears are justified and women also reported being forced to disclose their status after their partners or families found out that they had been for a HIV test. NDP counsellors encourage women to disclose their status to their partners and families as soon as possible after testing. VCT and community counsellors also act as mediators, if requested (e.g. if women fear violence) and, according to NDP coordinators, all mediated cases have so far been successful. Sharing experiences with other women in post-test clubs, such as in the DART project, or role-playing facilitated by ZAPSO, are cited as ways of empowering women to disclose their HIV status.

Counsellors view with great importance the need to develop better approaches to assisting young people in disclosing their HIV status to their sexual partners, friends and, particularly, their families. They believe this will also help other young people to attend VCT, prevent further HIV transmission, and prevent HIV-positive young people from becoming isolated and emotionally destabilized.

3.3 VCT service settings and management

The VCT services in the DART, NDP and TB/HIV Pilot Project are integrated into

health care facilities. ZAPSO and KCTT run free-standing sites as well as services attached to clinics. All sites provide a walk-in service and no appointments are necessary. VCT services are available during weekdays, with varying opening hours. Few sites are open on Saturdays. KCTT previously offered VCT services throughout the weekend and counsellors said that many couples preferred to come on Sundays. Due to financial constraints, these services could not be continued.

The ZAPSO project manager explained that, at the free-standing sites, considerable effort is being made to make the centre attractive to clients

A counselling session at ZAPSO. Counselling rooms are designed to make clients feel comfortable and relaxed.

The receptionist has been trained to welcome all clients and take them through to the waiting room where cold drinks are available. One of the counsellors then meets the client and takes him/her to one of the counselling rooms. The counselling rooms have been designed to make the atmosphere as relaxing as possible, with easy chairs and no desk to act as a barrier between the counsellor and client.

All projects seek to ensure **privacy** during counselling sessions, although lack of space, particularly in clinics, presents a challenge in some cases. The location of counselling rooms is often not private enough. Counsellors reported that, where VCT and other clinic services share the same waiting room, clients are sometimes reluctant to use VCT services because they fear being seen when entering the room. In one of the NDP clinics, new counselling rooms have therefore been created with project money. The rooms are located in a private area of the ANC and services are accessible to pregnant women as well as other clients. The rooms can also be used by community counsellors and their clients.

Management and coordination arrangements vary among the projects:

- The overall coordination of the DART VCT services is with the Perinatal HIV Clinic in the Chris Hani Baragwanath Hospital. Three counsellors in the DART project are responsible for coordination and daily management of VCT services in the hospital and clinics.
- In the TB/HIV Pilot Project, there is an overall project manager for all participating clinics and each clinic has a clinic coordinator responsible

for the project. The clinic coordinators manage various VCT service issues, including stock control, data collection for statistics, and the quality of testing. Management of staff, including lay counsellors, is the responsibility of the clinic managers who, in some clinics, are also the clinic coordinators for the project.

- The District Health Management Team (DHMT), in collaboration with LINKAGES, manages the NDP. The nurse in charge at the Lubuto Clinic, the DHMT HIV/AIDS coordinator and the community partnership coordinator, as well as LINKAGES staff have a supervisory function for VCT counsellors in all the clinics as well as managerial and quality-control responsibilities. Each clinic also has a nurse in charge of VCT.
- KCTT has one VCT coordinator for all six sites and one coordinator for community mobilization and the outreach programme. A senior nurse usually oversees the VCT services at each clinic.
- ZAPSO has a director to coordinate all VCT activities.

Lessons learned and ongoing challenges

Managerial support is critical

All projects agreed that a dedicated manager to give guidance, feedback and assistance with planning and training is essential, particularly when VCT services are being initiated. As summarized by the manager of the TB/HIV Pilot Project, "*You need support in the beginning to assist with the implementation process. It would be ideal if we had an implementation team, including nurses, managers and trainers that could move around the different facilities. Several people could then provide temporary additional support to staff in various ways. In some clinics, we have put an additional professional nurse, which was useful but also had its limitations because these people tend to become responsible for the project. The project then doesn't become adequately integrated.*"

Communities should be consulted about the location of new VCT sites

Consulting the community about the preferred location of a new VCT site is likely to increase the acceptance and usage of VCT services. ZAPSO and NDP set up their VCT sites according to the wishes of the communities that were to benefit. Whereas focus group discussions carried out by ZAPSO revealed the communities' preference for the VCT centres to be away from the hospital settings, formative research in the NDP revealed community members' clear preference for VCT services to be provided at health centres. People who feel uncomfortable being tested at their community clinic are encouraged in the NDP to attend another clinic for VCT.

3.4 Testing strategies

Four out of five projects (DART, some of the NDP sites, TB/HIV, KCTT) carry out on-site rapid testing, with results available within approximately one hour. One of the nurses states: "*Clients found that it is much better to have the results immediately. The anxiety is alleviated*". ZAPSO and some clinics in the NDP currently send all blood specimens to laboratories for testing and results are usually available after a couple of days and, in the NDP sites, sometimes also the same day. Despite currently not having same-day testing, return rates in both projects are high, with more than 95% of ZAPSO clients returning to collect their HIV tests results. Both projects are planning to do on-site rapid tests in the future, which will also reduce the transportation costs to the laboratories.

TB/HIV project: A nurse takes blood for a rapid HIV test

All sites where rapid testing is carried out follow largely the same protocol. When the first screening test is negative, the nurse completes the HIV register and the counsellor informs the client during post-test counselling. If the result is positive, a confirmatory test is performed immediately. If the positive result is confirmed, the test results are given to the client during post-test counselling. If the result of the confirmatory test is negative, some sites, including the TB/HIV Pilot Project[12] and the DART project, send a venous sample to the hospital laboratory for an Elisa test, whereas KCTT and the NDP counsellors themselves carry out a third rapid test in the case of indeterminate results.

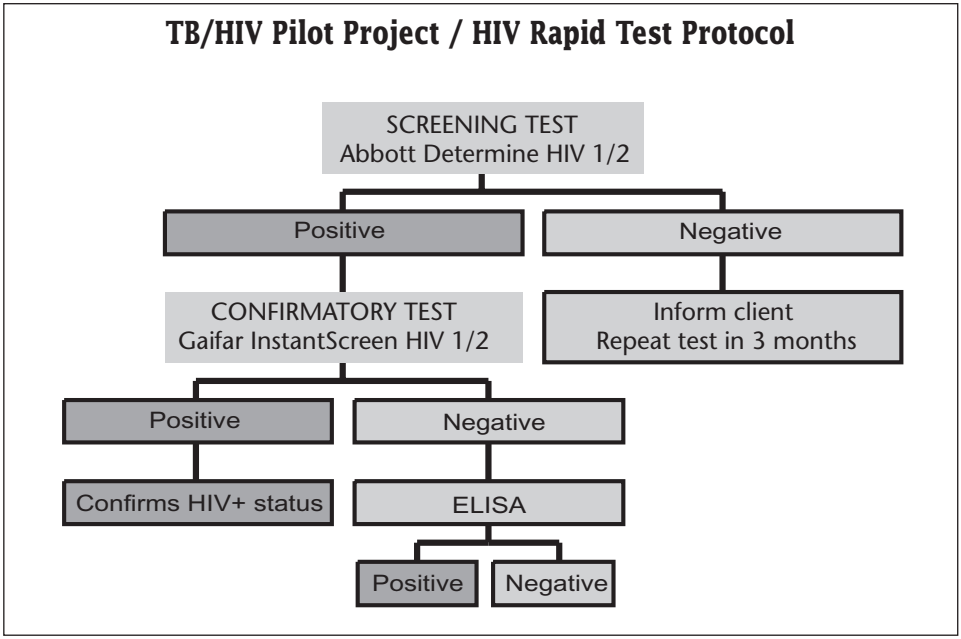
Lessons learned and ongoing challenges

Quality control should be given high priority

All projects emphasized the need to monitor stocks and ensure that the quality of testing is of a consistently high standard.

All sites keep lab record books in which each test kit is recorded and the staff in charge frequently do stock control checks of test kits. For example,

[12] *Among 900 positive cases in the TB/HIV Pilot Project in 2000, there were 11 indeterminate results, all of which were confirmed as positive on ELISA.*



Source: TB/HIV Pilot Project

the TB/HIV Pilot Project records the number of tests received, utilization of tests and problems that may be experienced. This is to ensure that test kits are accounted for and not 'removed' from clinics by staff or clients and used in inappropriate settings with inadequate counselling support.

Most sites also monitor the accuracy of testing through periodic tests on a certain percentage of blood samples. These tests are either carried out at the VCT centres or a sample of blood specimens is sent to a laboratory for independent testing. In clinics in the TB/HIV Pilot Project, for example, a quality check of the testing procedure is done by the 'area nursing manager' every six months, using a supervisory check list.

3.5 Target population and service usage

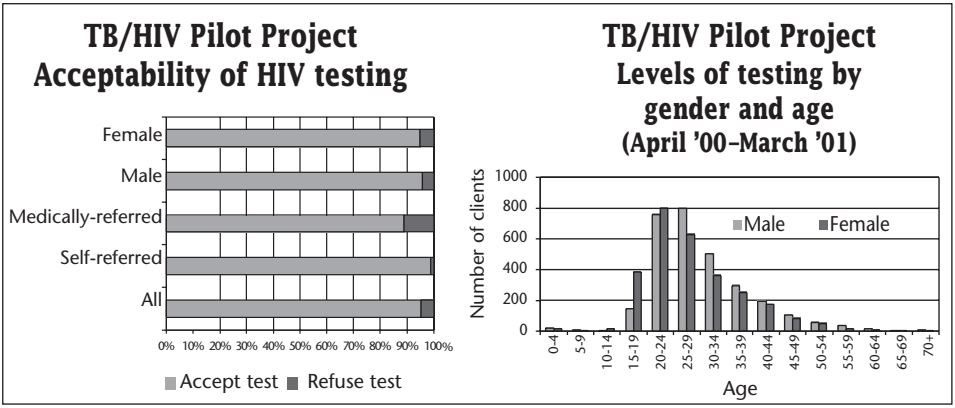
Target populations and service users vary considerably among the five programmes studied. Four of the projects (DART, NDP, TB/HIV Pilot, ZAPSO) aim to provide VCT services that are accessible to the general public,

although they may also include a focus on a specific client group. For example, in the NDP, the primary target groups are pregnant women who are attended by the antenatal services in the clinics and by traditional birth attendants at community level, as well as partners of pregnant women. In contrast, VCT services in the DART project are only available to women attending antenatal services and their partners. Some VCT sites see considerable numbers of clients from other communities who prefer to utilize services that are not in their immediate neighbourhood, for reasons of anonymity.

- **NDP** and **DART** services are mainly used by women attending antenatal services. In the NDP, a considerable part of the clientele also consists of women attending postnatal or curative services or being referred by community service providers. Between October 2000 and February 2001, the average antenatal clinic attendance rate per month at one of the clinics in the DART project (Zola Clinic) was approximately 250 women. In these five months, pre-test counselling was provided to 1243 women, of whom 88.6% chose to have a HIV test. In the six clinics participating in the NDP, 970 people utilized VCT services between April 2000 and February 2001, including 846 women and 124 men.

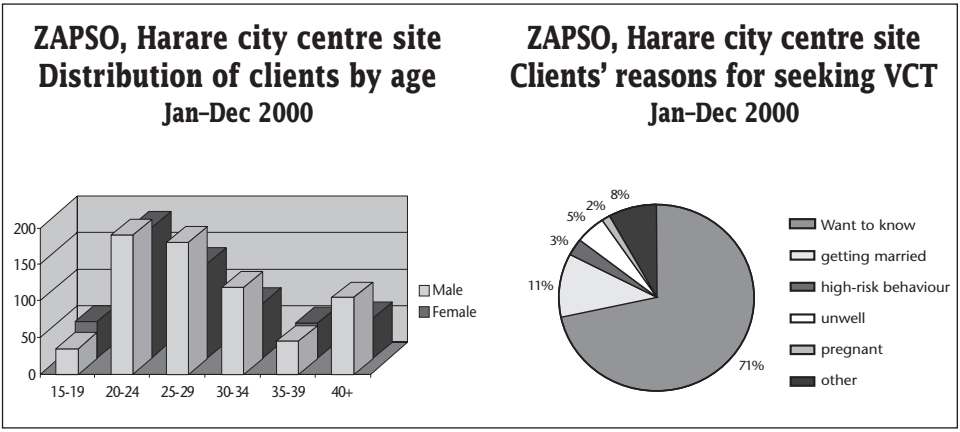
  In both projects, very few male partners of pregnant women come forward for testing. In the Zola Clinic (DART project), there were only 12 men over a five-month period. However, according to project managers in the NDP, the number of couples and men is slowly increasing, which might be related to the special efforts made in the NDP to promote VCT among men through community counsellors.

- In the **TB/HIV Pilot Project,** there were more self-referred than clinically-referred clients during the first year of the project (68% versus 32%). The trend is that more men than women use the service, in contrast to the general pattern of health usage. Utilization of VCT services by TB clients was not very high at the time of the survey. Although all project sites are located in Cape Town, the three clinics reviewed serve a rather different clientele. VCT services in the Chapel Street and Green Point Clinics see more commercial sex workers, and there are high numbers of refugees in the Green Point Clinic. Many clients visiting Chapel Street Clinic come from other communities and, as a consequence, it is more difficult to follow up with clients. The community served by the Langa Clinic is more cohesive and economically more deprived.



Source: TB/HIV Pilot Project

- Most clients at **KCTT** centres are self-referred, with approximately 70% having been recruited by community mobilizers. The number of referrals to VCT services from the clinics, including STI and TB clinics, is comparatively low. The majority of clients are between 18 and 29 years of age and, in general, there are more males than females. However, in some centres, especially the ones attached to clinics with ANC services, the majority of clients are female. With increasing numbers of VCT clients, the trend has been towards a decrease in the percentage of positive tests.



Source: ZAPSO

- At all three **ZAPSO** sites, VCT clients are mostly in the 19–29-year-old age group. In the Harare site, more men are seen than women. The majority of clients are asymptomatic, with only 5% of those attending describing symptoms that they worry could be due to HIV. Between 100 and 160 new clients are now seen each month, and 40% of people say that they have heard about the services from friends. The VCT service in the primary health clinic sees slightly more women than men as the site is situated near an MTCT pilot project, which facilitates referral for pregnant women with HIV. ZAPSO encourages young people to determine their HIV status before they form steady relationships. If a young person has no current sexual partner, he/she is advised to confide in a family member or close friend for support before having a HIV test.

The **minimum age** for attending VCT without parental consent varies depending on the country. In Zambia, young people under 18 need the consent of a guardian, except for pregnant girls and young mothers. In South Africa, it is national policy that the consent of a parent or guardian be obtained if a client is under 14. In Zimbabwe, young people under 16 legally require the consent of their parent or guardian. However, if they are living independently and already have a sexual partner or are pregnant, a HIV test can be considered.

Lessons learned and ongoing challenges

Partners/spouses of female clients require encouragement to utilize VCT services

The focus of the NDP and the DART project is on women attending ANC and their partners. However, the numbers of partners of pregnant women utilizing VCT services remain relatively low, although more and more women in the NDP share the test results with their partners, according to the LINKAGES adviser. A pregnant woman in the DART project commented: "*My husband doesn't want to come for testing. We are not using condoms, although I know it would be better for the baby.*" The fact that so few male partners/spouses are willing to be tested adds to the discrimination and isolation of HIV-positive women. Counsellors see the acceptance of a HIV test as a first step for men to take on more responsibility in the partnership, including being more understanding of, and involved in, prevention of mother-to-child transmission. This includes using condoms during pregnancy and being supportive of HIV-positive women's infant-feeding choices. Programme managers suggest that general VCT services for men and women outside the ANC setting will need to be made more avail-

able and promoted to facilitate testing of partners.

VCT for couples is receiving increasing emphasis

The projects reviewed generally seek to attract couples as it is counsellors' experience that adoption of risk-reduction behaviour can be enhanced when couples receive counselling and test results together. However, few couples are seen in the VCT sites of most projects. At ZAPSO, for example, the majority of people attending VCT sites come as individuals, but counsellors encourage people who are in a stable relationship to consider testing together with their partner. According to one nurse counsellor, *"It is much easier if they* (husbands and wives, or couples for premarital testing) *can come together for counselling and testing. At pre-test, we can go over all the possible results and enable them to plan what they would do in each situation. This means that, at post-test counselling, we can look back over what we had discussed. The most difficult situation arises when results are discordant, especially in [the case of] a married couple when the woman is seropositive".*

Counsellors agree that counselling couples is more demanding than counselling individuals. In the TB/HIV Pilot Project, couples currently receive pre- and post-test counselling as well as test results separately. Counsellors perceive that they would need more training to acquire special counselling skills and feel confident enough to deal with the emotional reactions of two people at the same time, particularly when results are discordant. According to a ZAPSO counsellor with a great deal of experience in counselling couples, *"Each case is different but, with sensitive, supportive counselling, we try and minimize the trauma and disruption that can follow discordant results. Sometimes couples will decide to separate, but more commonly couples are caring and supportive of each other. We will discuss safer sex and the importance of minimizing the chances of the negative partner becoming infected. A big dilemma for discordant couples is having children. For couples who do not already have children, they often express the desire to have a child and we will always support women and couples if this is their decision. If the woman is seropositive and becomes pregnant, we can refer her to one of the prevention-of-mother-to-child-transmission pilot sites in Harare."*

3.6 Community outreach

All projects recognized the importance of outreach activities to promote VCT use, especially in communities where services have been newly introduced and are not well known.

- The **DART project** does not have an outreach component but hospital and clinics have built strong links with NGOs, reaching out to communities in order to increase understanding and acceptance of issues related to MTCT and VCT. By involving communities, it is hoped that people will be better prepared for, and more tolerant towards, the increasing numbers of women who know that they are HIV-positive and possibly have HIV-positive children.

- The **NDP** outreach programme has been described in more detail in Chapter 2. Members of various community groups provide care and support, educating the community about HIV/AIDS and PMTCT and promoting VCT.

- To increase acceptance of VCT and the number of self-referred clients in the **TB/HIV Pilot Project**, approximately 400 members of the Langa community were being trained at the time of the survey to reach out to the community with prevention-education campaigns, including the promotion of VCT. A life-skills and peer counselling programme in Langa secondary schools is also part of the outreach programme. Women and young people under 18 are prime target groups. The programme is managed by a steering committee comprised of representatives of the Langa Health Committee, NGOs involved and project staff.

- **KCTT's** outreach programme with PLWHA and community mobilizers carrying out activities to educate about, and encourage, VCT use in the communities has also been described in more detail in Chapter 2.

- VCT is a relatively new service in Zimbabwe and **ZAPSO** is continuing to make potential clients aware of the availability of VCT and to promote its benefits. ZAPSO has outreach programmes at schools, colleges and workplaces. A new venture is working with churches and religious organizations not only to advocate VCT but also to foster a better understanding of the needs of people with HIV and to challenge stigma. Religious leaders have sometimes had a judgemental and negative attitude towards those with HIV but ZAPSO is helping to re-shape thinking and ensure a more supportive and caring approach. Training priests in HIV counselling as part of their pastoral care is also envisaged.

Lessons learned and ongoing challenges

Community outreach activities strongly influence VCT service utilization

Programme managers reported that the number of clients increases with the active promotion of VCT services through outreach activities. For example, the large majority of KCTT clients follow invitations of community mobilizers. When KCTT experienced financial downfalls during 2000, outreach activities had to be strongly reduced, which quickly resulted in reductions in VCT service utilization. Financial incentives for outreach activities can increase mobilizers' enthusiasm and the number of clients recruited for VCT, though managers are concerned about sustainability if funding is not secured.

3.7 VCT service provision

There are different models of VCT service delivery in the programmes reviewed. VCT counsellors are either paid staff or volunteers. There are counsellors with a medical background as well as lay counsellors. In the clinical setting, services are provided either with existing staff only or with additionally employed staff.

The two NGOs—**KCTT** and **ZAPSO**—employ counsellors who have mainly a background in nursing with additional training in HIV and general counselling. The NDP, DART and TB/HIV **Pilot Projec**t, which provide clinic-based VCT services, have different models of service provision:

- In the **DART** project, hospital and clinic staff members are currently not involved in VCT services, mainly because their workload is too high. Counselling is carried out by additional staff (psychologists and nurses) employed through the project, as well as by volunteers who are lay counsellors.
- In the **NDP,** counselling services are provided by nurses, clinical officers and lab technicians as well as by community service providers in collaboration with the clinic counsellors.
- In the **TB/HIV Pilot Project**, the majority of nurses at health centres receive training in counselling and testing and deliver the services on a regular basis. However, staff members at clinics have recently been rationalized and staff complements have decreased. With reduced numbers of staff, the increased VCT demands could not realistically be met with existing health workers, and additional staff members were recruited at each clinic to ensure that services could be available without delays. The shortfalls in

staffing are met by lay counsellors who perform most of the pre- and post-test and ongoing counselling, as well as by additional nurses who are involved in counselling and testing and clinical care. Some clinics also involve volunteers as counsellors. A number of VCT counsellors in their early twenties were recruited in an attempt to attract more young people to use the services. Some of the additional VCT counsellors are paid through project funds, whereas others are employed by NGOs and funded through provincial funds.

The length of pre- and post-test counselling varies depending on the client and clinic. The average length of pre-test counselling is similar in all sites, and counsellors generally take between 15 and 30 minutes for individuals and couples. The length of time needed for post-test counselling varies considerably. Sessions usually take between 20 and 30 minutes but some clients, particularly those who tested positive, require longer sessions, which may extend for up to two hours, in some sites. Due to time pressure, counsellors in some clinics take 10 minutes or less for post-test counselling if the result is negative. Several counsellors reported that there was often not enough time to have satisfactory preventative discussions with seronegative clients.

Lessons learned and ongoing challenges

Additional VCT staff can be required to complement health workers

Shortage of clinic staff and high numbers of clients may compromise the quality of VCT services. Adequate pre- and post-test counselling in clinical settings, in particular in combination with rapid testing and same-day test results, can often only be ensured by dedicating additional counsellors to VCT. *"If the additional counsellors hadn't been here, especially in the beginning, nurses would have been far more stressed and burnout would have been much higher,"* says one of the clinic coordinators in the TB/HIV Pilot Project. The project manager says that, from her experience, "*When you are dealing with huge uptakes, you need to have additional staff. The important thing with VCT is that if it is going to be used it has to be available. Working via an appointment system doesn't work in places where there are no phones."*

NDP managers reported that health talks in the ANC waiting rooms conducted by members of community support groups who also involve potential VCT clients in more in-depth discussions resulted in increased knowledge of clients by the time they saw the VCT counsellors. This helped to reduce the time needed for pre-test counselling.

Lay counsellors can make significant contributions

The manager of the TB/HIV Pilot Project emphasized that lay counsellors proved very capable in delivering adequate counselling services after they underwent training. They are, in general, well integrated into the clinics and are included in staff meetings. Integration has been achieved through ongoing efforts by project and clinic managers. One of the managers of the DART project also reported being satisfied with the work of lay counsellors. In the DART project, there are frequently clients who doubt the validity of test results given to them by the counsellors because they are not wearing uniforms like the nurses. Similar experiences led some lay counsellors in the TB/HIV Pilot Project to wear uniforms that look similar to those of nurses, which they reported increased their acceptance among clients.

In the DART and TB/HIV Pilot Project, some of the lay counsellors are volunteers. Some volunteer counsellors receive transport money but no other incentives. The TB/HIV Pilot Project coordinator explains: "*We started to train community volunteers as lay counsellors. In some of the clinics, the levels of HIV are fairly low. Because few HIV tests are done, one wouldn't want to put a full-time counsellor there. Some communities have very active health committees and volunteers work in the clinics on a regular basis. They were keen to get more involved in VCT. So we trained five volunteers in one of the clinics as lay counsellors. They get no incentives. It does seem to be viable. A volunteer would, for example, only work one morning a week. They are not expected to work every day. These lay counsellors also have mentors".*

Some of the lay counsellors in the DART project are HIV-positive. One of them explains, "*It's easier that I am HIV-positive myself because it helps me to understand how people feel when they are told that they are positive, and how to treat them. Because I know what it means to receive this news, I give more time and attention to clients."*

Programme managers emphasize that lay counsellors need ongoing training support and supervision if they are to remain motivated, well informed and not suffer 'burnout'.

Health workers should be prepared for the increased workload of VCT

Where VCT services were integrated into clinics, project and clinic managers made it a priority to prepare health workers for the impact of VCT on their workload, and nurses participated in decisions about their new counselling roles. The TB/HIV Pilot Project manager states: "*We told staff 'we are going to ask you to do more work'. It is clearly additional work and you have to recognize*

staff efforts and they need to be acknowledged for the extra effort they are putting in. Otherwise staff will feel abused". When VCT services are introduced in clinics, managers emphasize the importance of giving projects time to grow and stabilize before new components are introduced. One of the managers cautioned: "*One has to be very conscious of not overloading staff. Putting in place new services has been very difficult on staff. When you start coming in with something new too soon, it is quite problematic".*

3.8 Training of VCT personnel

Training strategies (including in-class and practical training) for VCT counsellors are similar in the five programmes.

- In the **DART project,** counsellors with a medical background receive training with a focus on PMTCT through the Perinatal HIV Research Unit. Lay counsellors who are members of NGOs undergo training with their NGO and receive further training when they join the project, including a two-week initial training course, refresher courses, and in-service training.

- In the **NDP,** various existing training curricula, including the Zambian HIV/AIDS training curriculum and the WHO/UNICEF infant-feeding training manual, were adapted to develop a course content to suit the specific needs of the project. All health-care workers undergo a 12-day training course covering issues related to HIV/AIDS, MTCT, infant feeding and VCT, including a short counselling skills component. Participants also observe breastfeeding practices and practise preparing replacement feeds under similar conditions to those of households in the community. After the initial course, staff members who show interest and are strategically placed to provide VCT services (e.g. ANC or family planning staff) are selected by trainers and senior health workers to continue with specific training, including psychosocial support and infant-feeding counselling. The course includes two weeks in class, five weeks' practical training under the supervision of senior trainers, and a concluding week's training in class. Health workers also regularly undergo on-the-job training.

- In the **TB/HIV Pilot Project,** a training institute provides training for health workers and additional counsellors. Similar to the approach of the NDP, all nurses at the pilot health centres initially attend a one-week HIV/TB/STI-awareness course. After

completion of the awareness course, a 12-day intensive counselling course is provided for those nurses who are interested in being more involved in VCT services. Project and clinic managers emphasize that only nurses who are willing to provide VCT services should participate in this course. For staff with previous counselling experience, a five-day HIV/STI/TB update and counselling review is offered. In addition, ongoing training of health workers in DOTS, STI syndromic management, rapid HIV testing, and HIV/AIDS is provided by clinic doctors and the project manager.

- **KCTT** counsellors' training includes a one-week initial course and six weeks of field training followed by a further week of classroom training. The course is well established and, according to the programme manager, has been refined over the years. A number of counsellors have also participated in additional training in more specific related areas.

- **ZAPSO** provides in-class, as well as practical, training for counsellors. ZAPSO recognizes the importance of in-service training and, in partnership with the USAID-funded 'New Start' social marketing project, joint training seminars are organized for counsellors from both services.

Lessons learned and ongoing challenges

Training of all health workers is recommended in clinics where VCT is introduced

Awareness training of all health workers on issues related to HIV/AIDS and VCT in clinics where VCT services are introduced contributes to better integration of services, and increases staff confidence and acceptance of services. Training also helps to demystify HIV/AIDS within clinics. *"As everybody got trained, it made it easier for the whole programme to become integrated. Nobody felt left out and we all knew what was going on. I would recommend that everybody in a clinic goes through the same training,"* said one nurse.

The overall quality of counselling improved in clinics with the introduction of VCT

Counselling is an essential skill in health care and clinic managers reported that, through VCT counselling training, broad capacity has been built in the clinics. The quality of services in general improved because nurses spent more time with patients and responded better to their psychosocial needs. However, in the TB/HIV Pilot Project this is also a problem because the main criterion for clinic funding is the number of patients seen, rather than the quality of services provided.

3.9 Management and mentorship of VCT personnel

All projects and NGOs have set up mentorship programmes for VCT counsellors to prevent burnout, provide psychological support, and also identify problems in service delivery. The mentors in the DART project, the NDP and the TB/HIV pilot project are usually external professionals who do not have a collegial or supervisory relationship with the VCT counsellors. Staff in the two NGOs (KCTT and ZAPSO) receive mentoring in sessions with senior counsellor colleagues. In most cases, mentors also monitor the quality of counselling. Counsellors and programme managers agreed that VCT service provision could be emotionally very stressful. As one of the counsellors reported, "*The first weeks after the training, I couldn't take the positive results, especially when very young people came in and turned out positive, because I compared them with my own children. Even now, it is difficult but the mentorship programme helps a lot. We tell our problems, sometimes we joke, and we discuss difficulties at work as well as our own problems at home*".

According to programme managers, mentorship and on-the-job training are critical components for ensuring quality assurance and, at the same time, providing support to the service providers.

In the **DART project,** the mentor is an external professional counsellor. The mentor meets with the group of counsellors once a week to discuss their cases and facilitate feedback.
Individual appointments are available on request. The group and individual meetings also give the mentor an opportunity to assess the quality of counselling, e.g. through exercises such as role-playing, and to make suggestions for improvements.

In the **NDP,** a team of advisers take turns in providing mentorship and support. The team of mentors includes members from PLWHA groups, the National Nutrition Commission, NGOs and community-based organisations, Ndola Provincial Counselling Council representatives, the District Health Management Team and the LINKAGES project. Counsellors also meet once a month, or more frequently, if necessary. The LINKAGES adviser explains: "*We are a team of mentors who look after each ANC clinic that is part of the project. Some of us are also trainers. We supervise counsellors during the training and afterwards, as well as other staff in the clinic involved in the project—for example, midwives. I spend one or two days a month in a clinic to see if all the basic procedures are followed and find out what problems staff*

are facing. I work with them to overcome the problems. I also sit in during counselling sessions. There is also a mentorship programme for the community workers. We just sit, for example at a weighing point, and observe and listen. That way, we can pick up problems and also see what they do well. We also do team-building exercises with health workers". Mentoring has been extended to community counsellors and community group members.

In the **TB/HIV Pilot Project,** nurses and lay counsellors see their mentors in small groups every two weeks. Mentors are usually external psychologists who debrief counsellors, teach stress management skills and provide advice about clients' problems. In addition, managers monitor how many clients a month each VCT counsellor sees. Managers report that this approach helps to pre-empt problems such as burnout from too high a caseload among lay counsellors. It also helps to identify nurses who need support and further training to overcome barriers to counselling and to ensure that counselling skills do not decline because of too little practice.

At **KCTT,** counsellors have individual support sessions with a senior counsellor every three weeks. Counsellors present case studies and the senior counsellors give feedback and also assess the quality of counselling. In addition, group supervision takes place once a month. This is further supplemented by a system of peer evaluation. KCTT also provides mentoring to outreach workers.

At **ZAPSO,** the director herself is a qualified counsellor and has organized in-house stress management training to prevent burnout. The senior nurse counsellor from the ZAPSO Harare site reported that working in a team and being able to discuss cases with colleagues is also of enormous benefit to her.

Lessons learned and ongoing challenges

Ongoing support to counsellors is required

Counsellors and project managers emphasized that VCT should not be introduced without psychological support to counsellors. VCT counsellors found that the fact that they could offload stress when interacting with their mentors was essential for good service delivery. One of the counsellors explains: "*She* (the mentor) *wants to find out what problems we encountered, what difficult cases we couldn't give advice on, things at work that didn't suit us or that worried us. She will tell us if we have addressed something properly and then she will add what we didn't address".*

The causes of stress should be identified and addressed

Managers and counsellors said that when health workers in clinics provide VCT services their increased workload can cause stress. As one of the project coordinators reported, "*If you really promote VCT, your numbers are going to go up and that adds to the stress".*

Rapid testing also often causes higher levels of stress for counsellors, particularly where nurse counsellors also frequently perform the tests. For example, when the TB/HIV Pilot Project was initiated, nurses found it difficult to report seropositive results shortly after pre-test counselling. One of the counsellors summarized: "*In the beginning, all staff were very apprehensive about rapid testing because we were in that mode of waiting seven days for the results and, during that time, we could psychologically adjust ourselves. But now, with VCT, we are affected more because we see the results unfold immediately. This is more stressful".* The project manager added: *"When you introduce rapid testing, it will always cause stress. You have a more intimate involvement with the client. Actually watching the test develop is very different to receiving the result later on".*

It is useful when trainers also serve as mentors

In the NDP and TB/HIV Pilot Project, it was found useful when some of the trainers from the counselling course also served in ongoing mentoring roles with the counsellors. This enabled the trainers to assess first-hand the effectiveness of training, the knowledge levels of counsellors and the appropriateness of their interactions with clients.

3.10 Post-test services

VCT clients who are found to be seropositive require medical care and emotional support to cope with their status. Clients who test negative may also require access to some form of ongoing support to remain negative. Some post-test services are organized by VCT service providers themselves but some of the support required is beyond their capacities. They can nevertheless serve as a key gateway to other service providers, such as health-care providers and community organizations that must play a vital role in HIV/AIDS care and support.

VCT service providers emphasized the importance of being able to offer support to people, especially to those who test positive, if they were to attract more clients. In an early study carried out at KCTT before it offered medical interventions for those testing positive, one of the main barriers to VCT service utilization was that clients

felt that there was nothing that could be offered to them if they tested positive. Clients who feel that they will be cared for after testing may be more willing to determine their HIV status.

One of the counsellors in the TB/HIV Pilot Project reported: "*Most clients ask before they give their consent to testing what we can offer them. This is one of the main questions coming up. When VCT was introduced, health professionals were positive about it because they saw the advantages for the clients and felt that they had something to offer".*

a) Emotional care and prevention support through ongoing counselling and support groups/post-test clubs

All projects organize support groups or post-test clubs and offer ongoing counselling to clients after VCT. These services are intended to give emotional support, help seropositive clients to cope with their status, disclose to their partners and families, and take measures to prevent MTCT and transmission of HIV to partners/spouses. Some support groups and post-test clubs are set up mainly for seropositive clients. Others also welcome people who tested negative to attend so that they may discuss strategies and acquire skills to help them remain negative. Activities in the groups include discussions, role-playing, and the sharing of individual experiences. Some groups also frequently invite experts to talk about topics of interest. Family and partner counselling is offered by most projects.

Support groups for HIV-positive women in the Chris Hani Baragwanath Hospital and the project clinics of the **DART** project offer a forum to discuss in more depth issues around Nevirapine intervention, breastfeeding and protection during pregnancy. Discussions and role-playing are intended to help women to disclose their status to their partners and family members.

Post-test clubs in the **NDP** are mainly frequented by HIV-positive pregnant women. The clubs meet every two weeks. In addition to discussions among participants, there are health talks from 'experts' about different topics such as nutrition and exercises. VCT counsellors encourage women to come for ongoing counselling after delivery.

Many HIV-positive clients in the **TB/HIV Pilot Project** see VCT counsellors for ongoing counselling, and support groups have been established in most project clinics. One of these groups also started a gardening and beadwork project. Clients who tested negative receive counselling to help them remain negative in the future.

According to managers, ongoing counselling services at **KCTT** are widely used by HIV-positive clients. Counsellors also provide advice and psychological support for clients who want to disclose their status and/or ask partners/spouses to come for VCT. Post-test clubs, as described in Chapter 2, also facilitate ongoing emotional support to both HIV-positive and -negative people.

ZAPSO makes referrals to a general counselling service in Harare for ongoing counselling, where required. According to the manager, the post-test support groups at the site in Chitungwiza have been very successful because VCT attendees are a cohesive group from a defined geographical area. Family counselling is also provided at ZAPSO. None of the counsellors has experienced very severe adverse consequences following VCT. *"This is probably because people who come to the centre really want to be tested and have thought about it. Plus we rehearse with them all the possible consequences following testing, at pre-test. So I think our clients are very prepared,"* says one of the nurse counsellors.

Lessons learned and ongoing challenges

Peer support after testing can help HIV-positive people to come to terms with their status

According to VCT clients and counsellors, support groups can be a source of comfort and strength and are a way out of the isolation that many people face after receiving a positive HIV test result. Spending time with people in similar circumstances, listening to how they feel about their status, the problems they face and how they deal with them, being able to speak openly about one's anxieties and hopes, and to laugh and cry together, has helped many people to cope with their status. Pregnant women and young people in the programmes reviewed were particularly appreciative of peer support groups.

Sustainability of support groups is a challenge

Managers report that support groups are not always successful and can run into problems. For example, the support group in the ZAPSO Harare site did not prove to be successful and was stopped. Counsellors attribute the failure to the clientele having come from a wide geographical area, seeking testing in central Harare because of its location near many workplaces. Similar experiences were reported in the Chapel Street Clinic in the TB/HIV Pilot Project. The support group in one of the clinics dissolved because most clients came from different parts of town and were not prepared to travel to the clinic every month.

Fear of stigmatization contributes to clients' reluctance to use post-test services

In the DART project, utilization of ongoing counselling and attendance at the support group are higher in the hospital than at the Zola Clinic. Counsellors attribute this to the clinic being smaller and offering less privacy than the hospital, resulting in some women fearing that they will be seen when they attend the group. It is counsellors' experience that women need time to come to terms with their status and often find the courage after a while to seek further support. Also, KCTT clients reportedly often choose to attend a post-test club that meets in another community to avoid gossip in their own neighbourhood.

Ongoing prevention services are essential

Male and female condoms are supplied free of charge in all projects. ZAPSO, for example, also gives information about where clients can receive further free supplies. KCTT counsellors also refer young people to 'youth-friendly services' (see Chapter 2) for further sexual and reproductive education, and condom provision. Safe-sex education, including demonstrations of both male and female condoms, is offered to all clients, where appropriate. Counsellors in the NDP and the DART project reported that women have great difficulty suggesting to their partners that they should use condoms.

Income-generation support provides an additional incentive for continuing participation

One of KCTT's free-standing VCT sites (Hope House) offers four-month vocational-skills-training courses to HIV-positive people, including tailoring and candle-making. Participants receive a certificate at the end of the course. KCTT helps to sell the products and money generated is shared among course participants. The project manager explained that the training has helped many HIV-positive people to come to terms with their status. However, after completing the course, participants often do not have enough financial resources to buy materials and generate income. According to project managers, the introduction of a small loans scheme could be of considerable benefit. With support from ZAPSO, a women's group has started a kitchen garden to supplement their income. Another group has arranged an income-generation project for selling second-hand clothes.

b) Medical care

HIV-positive clients in the five programmes did not have access to antiretroviral treatment at the time of the review, except for the short-course ARV intervention in the DART project to

prevent MTCT. The DART project, the NDP and the TB/HIV Pilot Project are all clinic/hospital-based projects, which facilitates access to medical care. The standard of care varies among the different clinics and the hospital, and it generally depends on the overall financial situation of the health system. Special clinics for HIV-positive patients are increasingly available.

- In the **DART** project, project doctors report that the Perinatal HIV Clinic in the hospital responds better than antenatal services in the primary health clinics to the special medical needs of HIV-positive pregnant women. Infants born to HIV-positive mothers in the DART project are followed up by project doctors during immunization appointments until they are one year old and are then tested for HIV. From the age of six weeks to one year, all babies receive co-trimoxazole as well as vitamins.

- In the **NDP,** one of the objectives is to reduce the risk of MTCT by improving the quality of care in MCH services, including antenatal, labour and delivery, postnatal, family planning, and child health services. According to managers, all women now receive better care and support before and after delivery. However, due to financial constraints, many essential drugs required for basic care were not available at the clinics at the time of the survey.

- In most clinics where the **TB/HIV** project is piloted, HIV clinics are established, and the standard of medical care is relatively high. This is partly because the health system in the Western Cape is relatively well funded. HIV/STI/TB training of all health workers ensures a continuum of care. With the initiation of the TB/HIV Pilot Project, managers report improved standards of medical care for HIV-positive clients.

- **KCTT** VCT counsellors ask clients who test HIV-positive if they agree to be screened for TB during post-test counselling and initiate isoniazid preventive therapy (IPT) depending on eligibility. X-rays are available only at one clinic. Clients on TBPT are entered in the ZAMBART (Zambia AIDS-Related Tuberculosis) programme. Clients receiving preventive therapy see VCT counsellors at the centre on a monthly basis for their drugs. Following health reforms in Zambia, clients have to purchase 'health schemes' in order to access clinic services. However, KCTT entered into an agreement with ZAMBART whereby, once a week, one of their doctors visits the clinics and provides free medical care to HIV-positive and -negative clients who have been referred through KCTT. According to outreach workers, this free medical care is an important incentive for

many people to go for counselling and testing.

- In the **ZAPSO** VCT site that is attached to a primary health-care centre, staff members have made it a priority to form a good relationship with the other health-care staff at the centre. They have held joint training seminars to ensure that they are well informed about the benefits of VCT and this has resulted in referrals between the counselling and other clinic staff. In general, **ZAPSO** has built linkages with other services, which offer longer-term support.

Lessons learned and ongoing challenges

VCT services challenge clinics' capacities to provide a broader package of care

Demands on clinics are high if VCT is the entry point to a package of care. Adequate medical care for HIV-positive patients is often problematic due to lack of funding and overstretched health systems. As the number of clients who know their HIV status is on the rise, demand for specific medical and emotional care, including ARVs, will increase and pose a challenge to service providers. As summarized by the TB/HIV Pilot Project manager, *"VCT services are fairly easy to establish, depending on the numbers of clients you want to attract. In some of our clinics, the demand for VCT has become so big that a huge infrastructure became necessary and space and resources from other services had to be allocated to VCT services. It's not about numbers of tests but about the quality of services and the ongoing support. The challenge we face is the shortage in our capacity to provide what I would consider adequate care.*

"It's very important to develop some kind of comprehensive package of care, including VCT, medical treatment and prophylaxis and community involvement. However, even clinics in close proximity differ hugely with regard to clients they serve and what they are able to offer. You have to tailor your package to suit the circumstances. You can't force clinics to implement what's beyond their infrastructure and capabilities. You have to have quite a substantial infrastructure in place to offer the full medical package. Not all facilities can offer all services as some are too small and, in others, the seropositivity rate is too low to justify this. Health authorities would like to have everything available at every clinic but I think this is not practical".

Integration of VCT services into existing clinical services

It was evident in all projects that training of health workers on issues related to HIV/AIDS and VCT facilitates the

integration of VCT services within the clinics. However, collaboration between VCT counsellors and health workers, and referral between VCT services and other parts of the clinics remain a major challenge.

DART counsellors, for example, reportedly work somewhat in isolation and there is some friction with nurses. Although the work of VCT counsellors is appreciated by the nurses, the latter report that they are not informed enough about counsellors' interactions with clients or the progress of the project. High turnover makes it a continuous challenge to keep all nurses informed. Also KCTT managers report that the number of referrals in the clinics where KCTT provides VCT services is still relatively low. However, in some clinics, the communication between VCT services and other clinic services works better because of monthly meetings of all clinic staff, including VCT counsellors and peer educators from youth-friendly services.

In the TB/HIV Pilot Project, despite the challenge of assuming managerial responsibility for lay counsellors, positive approaches have been identified. As one of the clinic coordinators reported, *"We made VCT part of the clinic. It is not a separate entity. All the staff members were informed about it; they are all part of the programme and they all know what goes on. All the professional nurses do counselling. As all staff members are involved, VCT is an integral part of the running of the clinic. Also the lay counsellors are part of the team and are included in specific meetings. When I talk about the team, I mean the whole clinic".*

TB/HIV project: The team of nurses and lay counsellors at the Langa clinic

According to project and clinic managers, integration can be facilitated through better communication, more regular meetings between VCT counsellors and clinic staff, and increased emphasis on sensitization of health workers to the benefits of VCT.

3.11 Information, education and communication (IEC) channels

Several approaches to informing and educating the public, such as outreach programmes and health talks in clinics,

have been elaborated in earlier chapters. In addition, a variety of support materials has been produced and the programmes seek to use media channels, where possible. Four of the programmes (DART project, TB/HIV Pilot Project, KCTT, ZAPSO) produced IEC materials in which the benefits of counselling and testing are explained and services are promoted. In the fifth, the NDP, materials are currently being developed. These include brochures, flyers, booklets, and posters. Materials are available at the VCT sites, and some projects, including ZAPSO and KCTT, also distribute leaflets in outreach sessions and make them available in clinics, workplaces and educational establishments.

Most of the materials used in the projects address a general client group. The DART project, however, uses brochures, which are specifically targeted at pregnant women: *HIV testing in pregnancy*; *I tested positive/negative—HIV and your pregnancy/Staying HIV-negative*; and *Disclosure*. ZAPSO prepared special booklets for men and women. Several projects show educational videos in the waiting rooms.

While radio and television advertising is too expensive for small NGOs like ZAPSO, managers take part in radio or television discussions about HIV and VCT and try to encourage journalists to write about the services.

Lessons learned and ongoing challenges

It is important to tailor IEC materials for specific client groups
Most projects reviewed make an effort to produce IEC materials in local languages. Except in the DART project, materials produced address a general clientele but programme managers emphasized that it is important to develop materials targeted at specific client groups. KCTT management, for example, plans to adapt their existing IEC materials to make them more suitable for young people.

3.12 Partnerships and linkages

All of the projects reviewed can be characterized as placing high priority on partnerships with other service providers, community groups and local governments.

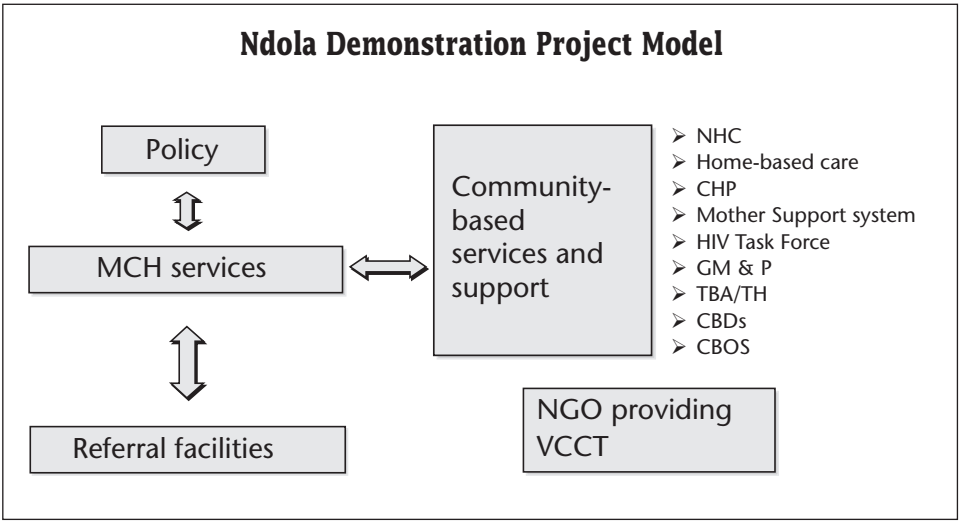
- The hospital and clinics in the **DART project** have built good links with community health committees, NGOs providing support to HIV-positive people, and organizations reaching out to communities to increase understanding and acceptance of issues related to HIV/AIDS. Collaboration between hospitals, clinics and NGOs that

organize support groups and home-based care for HIV-positive people in different areas of Soweto is well developed.

- One of the hallmarks of the **NDP** is the strong governmental, NGO and donor partnership. The main partners are the following:

  – National Food and Nutrition Commission, which coordinates all infant-feeding-related activities in the country and provides overall guidance and coordination to the NDP;
  – Central Board of Health (CBoH), the executing agency of the MoH, which ensures that the project is implemented in accordance with health reform strategies and provides HIV test kits through the National AIDS Control Programme;
  – District Health Management Team (DHMT), the implementing arm of the CBoH, which oversees health-care services—both at the clinic and community levels—and coordinates the health activities in the district. The DHMT is responsible for overseeing the planning and implementation of the NDP;
  – LINKAGES Project, a USAID-funded global programme that provides technical assistance and funding for the entire implementation, and works closely with the partners to advance the objectives of the NDP. Its responsibilities include renovation of Lubuto Clinic, training of health-care providers and community outreach workers, and assistance in monitoring and evaluation;
  – Hope Humana, a registered Zambian NGO that assists the Lubuto Clinic in HIV testing, counselling and laboratory work; links with the community and clinics; and helps organize advocacy events to sensitize stakeholders and decision-makers.
  – Zambia Integrated Health Programme provides most of the funding for the community trainings.

Ndola was chosen as a project site because a multisectoral District HIV/AIDS Task Force, as well as several community-based support groups (more under Chapter 2), had been set up in the district in previous years and were working well. The LINKAGES adviser explains: "*Initially, we looked at what was available at the community level so we did not have to introduce new structures*". A referral network ensures that people who attended VCT at the NDP receive ongoing care and support from other services sited in the



Source: LINKAGES

district. Several clinics and hospitals, NGOs, and the community support groups are part of this network. Besides introducing VCT, an environment has been created that reduces stigma, involves men, and increases acceptance of women's infant-feeding choices.

Clients are effectively referred among the member organizations using referral slips and a referral directory. Project managers report that the collaboration of community groups and health centres in promoting VCT, educating the public about HIV/AIDS and MTCT, counselling, and providing support to women who delivered, has improved referral capacities and taken some of the pressure off the overburdened health system.

- In the **TB/HIV Pilot Project,** the involvement of community stakeholders in project planning, development and coordination is seen as a priority. Where health committees and broad stakeholder forums exist, they are involved in the coordination of the project from the beginning, which is described in more detail in chapter two.

According to counsellors, community support for PLWHA is not yet

very strong and there were few community organizations set up outside the clinics that people could be referred to for ongoing support. Home-based care was better organized and provided mainly by two NGOs—the Red Cross and Philang. There is also a youth group—'*Vukani*'—that is active in raising awareness about HIV/AIDS and reducing discrimination against people living with HIV and AIDS. Other NGOs include Life Line, which provides counselling, and SWEAT and Triangle, which support commercial sex workers.

- **KCTT** VCT centres seek to involve clinic management, the District Health Management Team, and community health committees when new VCT services are set up. Community members assist with the dissemination of information at some VCT centres. KCTT also collaborates with support organizations for PLWHA. The four Lusaka VCT sites that are attached to clinics are run in collaboration with the District Health Management Team (DHMT) and the ZAMBART (Zambia AIDS-Related Tuberculosis) project. The three partners share responsibilities:
  - KCTT manages the services, including provision of counsellors;
  - DHMT provides the facilities free of charge (except in one site) and has seconded one staff member to one of the VCT centres (salary is shared between KCTT and DHMT); and
  - ZAMBART provides STI treatment for all VCT clients and medical care, including TBPT and TB treatment, for people who test HIV-positive; ZAMBART also finances the community mobilizers at one of the sites.

  KCTT has built partnerships with PLWHA support organizations but, according to counsellors, support systems (particularly for young people) are weak in Lusaka. They feel that stronger support networks are needed for those who test positive, as the existing services are not sufficient to address the particular needs of young HIV-positive people. Home-based care services are, in most parts of Lusaka, quite well organized and often run by church organizations.

- Following the development of the **ZAPSO** service, a social marketing VCT service funded by USAID—the 'New Start' Project—has also been established in Zimbabwe. ZAPSO and New Start have close linkages and counsellors from both services attend joint training seminars. ZAPSO does not aim to provide long-term support for clients following VCT and therefore has developed a wide referral network.

Linkages include:

- PLWHA support organizations;
- PLWHA treatment programmes, e.g. the Centre; ZAPSO has also arranged seminars for the association of family doctors to discuss the benefits of VCT and facilitate cross-referral;
- ongoing counselling for marital problems and adolescent and family counselling at Connect Counselling; and
- spiritual and religious support services, through a wide number of linkages developed with church and religious groups.

Lessons learned and ongoing challenges

It is important to involve the community in the development of new services

Project managers found it important to involve community stakeholders, representative bodies such as community health committees, and clinic management in the planning and establishments of VCT services. They strongly recommended that, before starting a new project or establishing a new VCT site, the objectives and implications for the community and clinics should be thoroughly understood by all stakeholders. The programme managers report that this increases the acceptance of new services, helps to ensure that there are no misunderstandings about the purpose, and raises stakeholders' interest in mobilizing the community to promote and use the services. As summarized by one of the nurses in the TB/HIV Pilot Project, "*When you are working with the community and you have a community forum, you have to work through them. You can't just decide to introduce and start something new. You have to consider the community*".

Building capacity in communities to provide ongoing support is important and requires time and resources

There are limits to VCT counsellors' capacity to provide ongoing care and support to clients after VCT. It is a continuous challenge to build capacity in communities to provide social support for HIV-positive clients, including income-generation projects and support groups for PLWHA. As one of the nurses in the TB/HIV Pilot Project observed, "*There is a gap in the community to provide care and support to PLWHA. There is only one social worker and we have to make plans to extend the support. We need to network with churches, traditional healers and schools. They are there, but each group works in its own corner, doing things their own way. We need to start building these networks*".

For example, the NDP project management emphasizes the importance of

building capacities in community groups and invests significant time and resources in organizing and providing ongoing training for the large numbers of community group members who want to participate in training courses. For the training, the same course content is used as for health workers, but adapted to suit their needs. In addition, community mentors had to be trained to support their cadres. Training is seen as an incentive among community health workers who report that they have more status in the community through their work. The coordination of community groups also requires time. Health workers are closely involved in the planning and monitoring of activities carried out by community groups. In each clinic, there are nurses who are focal points for the different community groups that monitor their work and collaborate with them on their outreach activities.

3.13 Monitoring and evaluation

All projects acknowledge the importance of having monitoring and evaluation mechanisms in place. Baseline surveys and situational analyses had been carried out in several projects before services started.

- In the **DART project,** a study was carried out with a sample of VCT clients using questionnaires to measure client satisfaction. The results have yet to be evaluated. Ongoing monitoring indicators include:
  - number of women booking at ANC;
  - number of women attending ANC accepting or refusing VCT services;
  - percentage of women testing positive and receiving or not receiving test results;
  - percentage of HIV-positive women who accept Nevirapine intervention;
  - percentage of HIV-infected women who choose to breastfeed;
  - number of women attending ongoing counselling; and
  - number of women who bring back their partners for testing.

- At the beginning of the **NDP,** a baseline survey on knowledge/attitudes about HIV/AIDS, MTCT, VCT, and infant-feeding practices was conducted among women in the clinic and community, service providers from health centres, and community-based organizations. Regular surveys following the baseline are conducted at 9-month and 18-month intervals to assess the implementation and a range of outcome and process indicators has been developed. The outcome indicators include:
  - exclusive breastfeeding rate of

infants 0-6 months, within the NDP catchment area;
- VCT acceptance rate among women who receive antenatal care at the NDP clinics;
- VCT acceptance rate among women who receive postpartum care at the NDP clinics;
- % of women with children aged 6-10 months who use at least 2 appropriate complementary foods, as recommended by MoH;
- number of tested individuals sharing results with partners or relatives; and
- number of staff able to provide good-quality counselling.

A VCT 'service-tracking sheet' is used to monitor VCT use and a set of indicators is used to monitor the project progress. Information is collected by VCT counsellors during pre- and post-test counselling, including data on sex, age, client category (i.e. ANC, family planning, youth-friendly service referral, community referral, others). Further information includes HIV test results, number of test results collected, and referral of clients for further support. Managers also plan to monitor the utilization of referral services. Operational research is ongoing to learn more about decision-making, coping with positive results, maintaining a negative status, and infant-feeding choices. Community groups keep records and frequently send reports to the health workers so that their activities can be monitored and coordinated with the clinics.

- In the **TB/HIV** Pilot Project, a baseline assessment of TB and HIV services was carried out before the project was initiated. A number of indicators have been developed to monitor the access to VCT services in the district on a regular basis, including the number of:
  - health facilities offering VCT services in the district;
  - health facilities offering rapid testing in the district;
  - people tested for HIV in the pilot facilities;
  - people who self-presented for HIV testing in the pilot facilities;
  - people who ever received HIV test results;
  - people who received same-day HIV test results;
  - people who were HIV-positive;
  - TB patients registered in the district during one quarter of the year;
  - TB patients who receive HIV pre-test counselling;
  - TB patients who are tested for HIV; and
  - TB patients who are HIV-positive.

  As a part of routine monitoring, VCT counsellors complete a HIV

test form with information about the patient during the pre-test counselling session. Future plans include the monitoring of outcomes of VCT services, such as changes in sexual behaviour, disclosure of HIV status, and uptake of ongoing counselling.

- **KCTT** counsellors collect a variety of client data during pre- and post-test counselling. This includes personal data, general HIV/AIDS knowledge, medical history, risky behaviour, beliefs related to VCT, and intentions to change behaviours. There have been several studies carried out at Kara looking at behavioural change following VCT, barriers to testing and coping following VCT. KCTT management reports that day-to-day monitoring and evaluation mechanisms need to be strengthened and data fed back to the counsellors to give them a better understanding of their achievements and aspects that could be improved.

- **ZAPSO** developed its service following an in-depth situational analysis. It continues to monitor and evaluate the service to ensure that quality is maintained and that the service can respond to the needs of its clients. All clients complete a short questionnaire before seeing the counsellor. This contains information such as demographic data and reasons for testing. All clients are also asked to fill in an anonymous exit questionnaire about the service. Suggestions from this have led to changes in the service[13]. ZAPSO is also planning a longer-term follow-up to assess behavioural change and other consequences following VCT.

Lessons learned and ongoing challenges

Improved feedback is required to guide programme efforts

Programme managers appreciate monitoring and evaluation mechanisms that allow for continuous feedback to managers and VCT counsellors about the status of services provided and the progress made. They further appreciate that feedback mechanisms can increase the knowledge of staff involved in the programme and can guide future improvements. Particular priorities noted were information on uptake of VCT services required to guide outreach efforts with specific target groups, and monitoring data, which can guide strategies with respect to increasing acceptance of HIV testing.

[13] *For example, clients stated that they did not enjoy seeing HIV/STI health education videos in the waiting room as they were already anxious about testing and they preferred to read magazines or watch television.*

Further long-term follow-up information is required
There is little information on the long-term outcomes for people who have attended VCT. Although several studies have shown that people—both those who test positive and negative—do make changes in their sexual behaviour in the short and medium term following VCT, there are few longer term follow-up data available.

Quality control is a priority
Programme managers report that mechanisms to evaluate the content and quality of counselling will be required if counselling quality is to be maintained in the long term. In the reviewed projects, the quality of counselling is generally monitored through case presentations and role-playing during sessions with mentors. Programme managers note the need for more objective assessment tools to complement this qualitative approach.

3.14 Funding and costs

All five projects provide VCT services free of charge[14], although there are usually hidden costs for the clients, such as transport costs to the VCT facility and time off work. To date, VCT services in the five programmes have been financed through grants or subsidies from national governments or international donors.

The costs[15] of VCT services and ARVs in the **DART project** are covered by several non-profit organizations and the private sector. Project managers hope that the government will take greater organizational and financial responsibility for service provision in the future.

In the **NDP,** the Zambian Government included Ndola as one of the 22 government-run VCT sites and covers the costs of HIV test kits and other equipment as well as the laboratory staff at the Lubuto Clinic. LINKAGES (a USAID-funded global programme) covers all other expenses.

The South African Department of Health funded the **TB/HIV Pilot Project** for the first two years with 1.7 million

[14] *KCTT officially charges 500 Kwacha (approximately US$0.13) for a HIV test in one of the freestanding sites, but clients who can't pay are still tested.*
[15] *Costs include: initial and confirmatory test: US$1.50 each; Nevirapine intervention: US$3.25 for mother and child (tablet and syrup)*

Rand[16]. The local and provincial health authorities also carry costs (e.g. the employment of additional counsellors, costs of HIV tests and medical treatment). To ensure continuation in the pilot districts and to expand the project to other districts, multi-year support has been requested from bilateral donors.

KCTT VCT services are funded mainly by NORAD, the Norwegian bilateral agency. Zambian VCT service, a government agency, provides the test kits. ZAMBART covers the costs for mobilizers in one VCT centre, including payments for mobilization, training and supervision. Unit cost of VCT was estimated to be US$7 in September 2000.

ZAPSO is a national NGO and receives both donor and government funding. The major donors are currently the Dutch Government, UNFPA and the Oak Foundation. ZAPSO works closely with the Ministry of Health and uses Ministry of Health guidelines.

Lessons learned and ongoing challenges

Ensuring sustainable funding for VCT services

The cost of current service models, including staff and supplies, exceeds what could likely be supported through user fees, so ensuring sustainable funding remains a major challenge.

KCTT, like many other NGOs, continues to experience financial constraints, despite a track record of delivering good-quality services for many years. Managers report that it is problematic but desirable to secure multi-year funding and to diversify support among a variety of donors, rather than depending on only one source of funding. This approach might be a way to minimize financial downfalls. Careful planning and monitoring of activities, especially when scaling up services, is also important.

In Zimbabwe, as in other countries, the costs of providing VCT services are relatively high. This is because, in Zimbabwe, trained counsellors provide all counselling and the test kits themselves remain expensive. When ZAPSO first began to provide VCT services, a subsidized fee of 150 Zimbabwe dollars[17] was charged for the service. However, following a trial period, when the service was provided free of charge, an increase in attendance was noted, and it was recognized that even the subsidized fee was too high for many clients. Currently, all services are free, with

[16] *US$1 = 8 Rand (approximately, in May 2001).*
[17] *US$1 = 55 Zimbabwean dollars (approximately, in April 2002).*

funds supplied by the NAC (the National AIDS Committee). This policy will be reviewed periodically. It is hoped that the costs of HIV test kits will be reduced with time, but managers are concerned that providing high-quality individual counselling will always be relatively costly. Therefore, ongoing funding remains a concern and has hindered the rapid scaling-up services.

Another major problem for ZAPSO is the retention of staff. National counsellors' salaries are relatively low and economic instability has meant that ZAPSO has found it difficult to retain staff, particularly in Harare where the cost of living is high and there are many opportunities for well-qualified experienced counsellors in international NGOs and other posts. This can be frustrating for a small NGO and expensive in terms of training.

Conclusion

This booklet describes VCT service delivery in five different settings, with varying capacities, targeting different populations and providing a range of services following testing. This highlights the need for VCT not to be seen as a uniform intervention. VCT should be flexible and adaptable to the needs of the population it serves. It is unlikely that one model will be suitable for all populations. Approaches enabling pregnant women to access VCT and PMTCT interventions will differ from approaches aimed primarily at providing diagnostic and ongoing supportive counselling for people attending medical services. All the approaches described in this document have been demonstrated to be feasible and acceptable, but many challenges exist if rapid scaling-up of services is to occur.

Stigma remains a major barrier to people accessing VCT and taking part in post-test support activities. However, many of the projects described are new, having been developed over the past three years. It is hoped that, as increasing numbers of people undergo VCT, this will have the effect of reducing stigma and enhancing normalization and acceptance of HIV and VCT in the community.

There is increasing evidence showing that VCT can play an important role in helping people to change their sexual behaviour and thus reduce HIV transmission. However, this is most marked when couples are tested together. In all the projects described, only a minority of people attending VCT came with their partners. Sharing HIV test results with partners is also often noted as being difficult, especially for seropositive women.

This is a particular problem for women attending VCT services in ANC clinics, which very few pregnant women attend with their husbands/ partners (DART project and the NDP). Pregnant women who receive VCT alone may be left vulnerable and unsupported if they cannot share their HIV test results with their partner or a close family member. Counsellors who have had training in providing pre- and post-test counselling sometimes report difficulties in counselling couples. Innovative ways of reaching couples must be sought and counsellors provided with ongoing training and support so that they can provide effective couple counselling and feel confident in helping couples with communication problems.

The target populations and service users vary considerably among the five services studied. Four of the projects (NDP, TB/HIV Pilot Project, KCTT and ZAPSO) aim to provide VCT services that are accessible to the general public, although they may also include a focus on a specific client group. Most VCT services recognize that targeting young people is of great importance in sub-Saharan Africa where the potential for VCT as an important intervention in HIV prevention is greatest in this group. KCTT demonstrates good results in attracting young people with services specifically designed for young people or counsellors trained to respond to the special needs of young people. An increased focus on the provision of VCT services for young people and ongoing training for counsellors in youth counselling is recommended for all VCT service providers.

Rapid HIV testing is used in four out of the five projects and will be introduced into the ZAPSO sites in the very near future. The advances in rapid HIV testing technology allowing HIV tests to be carried out by non-laboratory personnel, with minimal equipment and using test kits that can be stored at room temperature, will enable VCT services to be developed much more widely. Most VCT clients prefer to receive their test results without delay and, despite some initial misgivings, counsellors also find rapid testing to be acceptable and beneficial to clients. Counsellors recognize that, if rapid testing is used, they must give clients the option to refuse or defer testing, particularly in settings where they are not attending explicitly for VCT (such as in ANC or primary health-care settings). Because accuracy of HIV testing is so important, external quality control is carried out at all VCT sites using rapid testing algorithms.

Current VCT provision is sometimes seen as too time-consuming for counsellors. It has been proposed that pre-test counselling could be reduced to a very short session or largely replaced by group information sessions to enable larger numbers of people to benefit

from HIV testing when there are limited numbers of trained personnel. However, all the VCT services studied reported that providing adequate, ethical pre-test counselling required at least 15–20 minutes, and none felt that it would be acceptable to provide a much shorter pre-test session. Some staff reported that when they felt pressurized or had inadequate time to spend on pre- or post-test counselling they felt that they were unable to provide sufficient support for their clients. The staff requirements (numbers and training) should not be underestimated when planning to boost VCT services in sub-Saharan Africa. If nurses are already overburdened in health-care settings, training of other cadres of workers could be considered. Ongoing support and supervision of counsellors, whatever their background, must be ensured if high-quality counselling is to be provided and burnout of counsellors avoided.

Although VCT has been shown to be a cost-effective intervention in reducing HIV transmission, it is relatively costly and ongoing adequate funding of some of the VCT services described has been difficult to achieve. Poor or inconsistent funding is demoralizing for counsellors and leads to a high level of staff turnover as trained staff leave for better-paid or more secure jobs.

VCT is often only the first stage in the care needs of people infected with HIV. In all VCT services described, post-test clubs have been formed whereby some people can receive ongoing emotional support. Most projects refer to other support groups and counselling agencies for ongoing psychological support. The TB/HIV Pilot Project sites provide comprehensive medical care for seropositive people following VCT. For the majority of the other sites, ongoing medical care is a challenge. The uptake of these ongoing care and support services and the long-term outcomes for people following VCT are not known. Although follow-up after VCT is difficult, particularly in sites where anonymous VCT is offered, operational research to determine the long-term outcomes of VCT should be considered, to ensure that people (particularly those who test seropositive) are not left unsupported and disadvantaged following testing. Outcomes for young people following VCT are also very poorly understood. There is an urgent need to develop effective behavioural interventions to help young people sustain safer sexual practices following testing and emotional support options adapted for the needs of young people who test seropositive. These interventions will also need careful evaluation.

There is widespread international support for the rapid expansion of VCT as a component of HIV prevention and to enable seropositive people to access

Conclusion

care including ARVs and PMTCT interventions. The projects described illustrate effective approaches to VCT delivery but also highlight the challenges and other service requirements that will have to be developed in parallel if the rapid scaling-up of VCT is to be effective and successful.

ANNEX I – Contact details

To obtain further information about the individual projects reviewed in this publication, the following people can be contacted:

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together eight UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its eight cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners—governmental and NGO, business, scientific and lay—to share knowledge, skills and best practice across boundaries.

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HIV voluntary counselling and testing (VCT) is the gateway to both prevention and care, playing an important role in helping people to change their sexual behaviour and thus reduce HIV transmission. VCT services are being more widely promoted and developed and many countries are gradually instituting VCT as part of their primary health-care package.

The aim of this booklet is to describe the experiences of, and challenges faced by, five programmes in sub-Saharan Africa, which developed effective practices and implemented successful approaches to VCT in relation to four key thematic areas:

- prevention of mother-to-child transmission (PMTCT)
- tuberculosis (TB)
- young people
- general population groups.

The programmes operate in low-resource settings and many of the experiences and lessons learnt may be transferable beyond country and culture, and strengthened through community mobilization and public policy measures. This booklet highlights the need for VCT not to be seen as a uniform intervention but as a flexible service that can be adapted to the needs of the population it serves.

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